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ORTHOPEDIC PREVENTIVE MEDICINE*

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CHICAGO

Preventive medicine carries a wide social implication, since, by maintaining a high ratio of sound and efficient individuals, it reduces proportionately the burdens and problems imposed on the state and society by the physically handicapped. Orthopedic surgery can claim a modest share in the development and application of methods of preventing disease, although our specialty is generally considered as only loosely associated with those that are recognized as having made the most important advances in preventive medicine. By devoting this paper to the prevention of deformities, I hope to bring to the attention of the medical profession a realization of the effective work now being done, and of the possibilities of wider cooperation within the medical profession and with the various social agencies concerned with children and with industrial conditions.

I have selected five types of cases frequently recurring in orthopedic practice through which to demonstrate the possibility of the effective prevention of deformity: fractures; congenital clubfoot; rachitic deformities; traumatic spastic paralysis, and epidemic poliomyelitis.

UNFAVORABLE FRACTURE RESULTS

Every orthopedic surgeon sees many cases of deformity and of chronic lameness that are unquestionably the result of ignorance or carelessness in the first treatment of fractures. We are forced to admit that a large percentage of the useless joints brought to us after earlier treatment could have been prevented by proper handling at the beginning. It is unfortunate that the plaster cast, so neat and valuable in maintaining position, often conceals an unsuccessful effort to reduce a fracture of which the operator is fully aware. The use of ambulatory splints adjusted by mechanics and salesmen cannot be too severely condemned. The first responsibility in this matter rests on the medical schools and the hospitals, where, frequently, not enough importance is given to the proper handling of fractures to break down the all too common idea that the treatment of fractures is just a sort of "first aid." We must not be surprised at encountering this attitude among licensed practitioners, unless we constantly impress on students and interns, as a great orthopedic principle, that *no fracture is properly handled unless in the long run it secures to the patient the maximum of function and the minimum of deformity possible under the conditions.*

In industrial cases, the services of even fairly well trained surgeons are often not available at the moment when efficient and preventive care is needed, because the conditions as to time and pay made by the companies are not generally of the sort to attract such men. Consequently, deformity and impaired functioning of the injured part often force the victims of industrial accidents to seek further treatment, although their compensation has been settled on the basis of having already had the best. The insurance companies, however, by insisting on the early return of their patients to work, are stimulating better care in the handling of their cases. Indeed, though it may be a matter of contract and a financial proposition for them, insurance companies are among the foremost agencies working to secure improved health and increased efficiency for the individual.

The idea of organized cooperation in our great industrial centers between the employers, the physicians, the insurance companies and the social agencies that ultimately have to meet the problems of unemployment through industrial accidents offers almost unlimited possibilities for correcting the abuses now prevalent, and securing for all injuries careful and intelligent handling from the beginning.

Among other things, supervision of young underpaid company physicians by experienced orthopedic or industrial surgeons, or more frequent consultations, would go far toward the prevention of subsequent operations, with the consequent loss of time and economic hardship for the individual.

CONGENITAL CLUBFOOT

The early nonoperative method of handling clubfoot has accomplished much toward the prevention of deformity growth and in the securing of a high degree of functioning power. Here, again, the orthopedic surgeon must have effective cooperation from the obstetrician, the pediatrician, the parents and the nurse, in order to begin treatment at an age when the tissues of the clubfoot, placed in a corrective position for growth, will earliest assume a natural direction. Treatment should begin in the first months of life, and should consist of simple, painless, daily manipulation by the nurse or mother under the physician's direction.

At 2 or 3 months, many of these feet will accept a carefully applied plaster cast or glue bandage, maintaining the slightly corrected varus and equinus, and extending from the toes to the trochanter, over the knee bent at right angles. In two weeks another cast may be applied, easily obtaining more correction. In this way, with successive casts, each securing additional correction, a congenital clubfoot may become entirely overcorrected without operation. During the last five years in cases in which the cooperation was satisfactory, I have used no knife in the correction of clubfeet which

* From the University of Illinois College of Medicine.

* Chairman's address, read before the Section on Orthopedic Surgery at the Seventy-Fifth Annual Session of the American Medical Association, Chicago, June, 1924.

were under treatment by the third month of life. Feet treated in this way approach the normal in a surprising and gratifying manner, and save the patient both the embarrassments of deformity and the shock and pain of later operation under anesthesia.

THE PREVENTION OF RACHITIC DEFORMITIES

Deformities resulting from rickets present an entirely different type of case, and one of equal interest to the pediatrician, the obstetrician and the orthopedic surgeon. Usually, the bone surgeon sees these cases after the deformity is present, often in adult patients, as rachitic deformed legs. His interest is mainly in the correction by operation of leg deformities that have not been prevented. These deformities, occurring often during pediatric care, not only are preventable but also are the minor ones developing from rickets.

What we must acknowledge as the really serious deformity, that of contracted pelvis, is, I believe, also preventable by the use of early predeformity prone treatment. This should be enforced on the gas pipe frame, so that no weight or pressure will be borne by the pelvis or the legs, either in standing, or in resting, folded over the patient's abdomen (a common posture in rickety babies), or when being carried on the mother's hip—a position causing great strain to the legs and pelvis of the child. Also, if children were not allowed to sit up during the soft bone stage of rickets, a large number of rachitic deformed pelvises would be prevented, and the number of cases requiring cesarean section would be greatly reduced.

It is unquestionably the function of preventive medicine to make the connection between cause and effect, even when they are as widely separated in time as the rachitic girl baby and the woman whose labor is rendered difficult or impossible by a too narrow pelvis. The securing of predeformity treatment for rachitic children involves not only better cooperation between the pediatrician and the orthopedic surgeon, but also the education of teachers, nurses, playground directors and all having to do with children, as to the consequences of neglect during the early processes.

The suggested cooperation between the pediatrician and the orthopedic surgeon should be brought about by more frequent consultations regarding the care of these children, from both the standpoint of feeding or treatment of rickets and the prevention and correction of deformities. The pediatrician may concentrate his efforts on the cure of the rickets while the deformity of the bones takes place, because the child sits and stands before their ebonization. On going to the hospital, the rachitic child should be entered on the combined services of pediatrics and orthopedic surgery.

TRAUMATIC SPASTIC PARALYSIS

The case of spastic paralysis represents probably one of the greatest problems with which the orthopedic surgeon is confronted. Along with the patients, he suffers a feeling of hopelessness toward all efforts to improve the condition of these helpless and afflicted children.

Inquiry into the history of such cases, from our clinics, reveals the fact that difficult labor caused the majority of them. This leads us directly back to the problem of the contracted pelvis, with careless, hurried or unintelligent deliveries, as the chief factor in preventability.

The use of forceps is also responsible for a certain number of cases of spastic paralysis. In an orthopedic clinic, recently, six of these patients were found among the thirty-two children brought in for examination. It developed that the use of forceps in cases that had not been long in labor was a common practice in that region. One mother, who was questioned, spoke quite familiarly of "prophylactic forceps." All this suggests immediately the need of thorough cooperation between obstetricians and orthopedic surgeons for early and scientific treatment of the rachitic child, in an effort to prevent contracted pelvis, and for more careful education of the family physician as to the dangers attending the indiscriminate use of instruments in confinement cases.

EPIDEMIC POLIOMYELITIS

An outstanding example of community cooperation for the prevention of deformities is afforded by our experience in Chicago in connection with the epidemic of poliomyelitis in 1915, when the commissioner of health used his authority to enforce the hospitalization of infantile cases.

A wing of the county hospital was appropriated for this purpose, and all agencies dealing with children were enlisted in the effort to discover and report cases.

In the hospital, the correct position of the paralyzed body and the limbs was strictly maintained during the acute and subacute stages of the disease; and, in the cases requiring it, the patient was dismissed with plaster supports.

The necessity for follow-up care was realized, and the cooperation of a nursing organization was obtained for this purpose. A few of the nurses were especially trained for infantile treatments, which were given in the homes of the patients dismissed from the hospital, with periodic visits to a supervising orthopedic surgeon regarding further treatments.

Such a plan, actually working, practically eliminated later corrective operations on this group of children, leaving only the stabilizing operations as the main work the surgeon now gets. Moreover, it was the beginning of a very important expansion of the work of the Visiting Nurse Association and of the development of a department for the study of infantile paralysis, with a group of nurses trained for examining infantile cases and giving orthopedic treatments in the homes.

The annual report of the association shows that, during 1923, 17,053 home calls were made by the nurses of this department, and 5,908 treatments were given crippled children in schools and clinics. Starting as emergency cooperation, produced by a dread epidemic, this surely points the way to unlimited preventive work, which may be accomplished by the organized efforts of such agencies in normal times.

PSYCHOLOGY

There is, however, a factor in preventive work, which, though seemingly negligible, is in reality one of the strongest obstacles we encounter: I mean the psychology of the crippled child.

In using the term "psychology of the crippled child," I include not only the behavior reactions of the child itself, but also the attitude toward the child of all who are associated with it—parents, companions, nurses and physicians. We have to do, therefore, with the psychology of a situation of which the crippled child is a part.

In this situation, the outstanding element is the fact that the crippled child, whether in poor, moderate or opulent circumstances, is almost invariably a spoiled child. The process of spoiling is twofold. On the part

of the parents, it is the result of the expression of natural human affection in a peculiar situation that makes of the child an object of especial attention and devotion. On the child's side, it is almost invariably the tendency to exploit his handicap for the purpose of securing still further notice and indulgence.

Certainly, the crippled child is entitled to special attention. But, more than this, it is well known that parents always have an overflow of sympathy for an afflicted child in excess of what they feel for a normal and robust one; and in their treatment of such a child they attempt not only to compensate him for his defect, but also, quite unconsciously, to relieve their own feelings of distress and tenderness. And sympathy in these cases is not confined to parents; brothers and sisters, playmates and teachers, and even nurses and physicians quickly acquire it, and the child finds it easy to dominate the little world of which he is so pathetic a center.

The great majority of crippled children are quick to press to the utmost their demands for exceptional attention, and this has a direct bearing on all such cases from the standpoint of care. The influence of the unfortunate child on its parents and relatives is such that, in a lamentably large number of cases, its unwillingness to be taken to a physician or a hospital results in failure to secure any treatment whatever.

Thus, many children afflicted with various types of bone, nerve or muscle diseases, in which early treatment would prevent a lifelong crippled condition, are too often not seen by a physician at all. Others may be seen only after the actual deformity takes place. With the late treatment, as is well known, although disease may be arrested and overcome, the lost tissue cannot be replaced. Again, many deformities, such as clubfoot and congenital hip, though they can be corrected later in life, give far better results and often leave no sign of the crippled condition if corrected when the child is very young.

I need not point out that the prompt hospitalization of the patient has advantages over treatment in the home, however favorable the home conditions may be, not alone because of the superior organization of the physical environment in the institution, but also because of the opportunity afforded there for correcting bad habit formation in both the child and the parent.

The crippled child may, indeed, be said to be unfitted for normal life in two ways; that is, from the standpoint of physical disability and in respect to his psychologic attitudes. What psychologists call bad habit formation or, in plainer language, being spoiled, means that the child is not able to share in the ordinary give and take of family life, but expects and receives the exceptional treatment which we gladly give the sick, temporarily, but which is very unfortunate as a general policy from the standpoint of education, character development and life habits.

It is in this connection that the hospital or the special school is of peculiar value to the child. The association with other crippled and sick children, many of whom are worse off than himself, in a place where everything is regulated for the group, instead of for the individual, makes for a remarkable change in his mental attitude. A socialization of his impulses and interests takes place, which is all the more valuable because unconscious.

By sharing community interests, the child has his ego subordinated, and his tyrannical demands are modified in a way that astonishes the parents. From a social standpoint, the child's new attitude and behavior are fully as valuable as the correction of the physical deformity, especially as the reform is in most cases a lasting one, the beneficial effects of which continue to be shown in home and school life after the child's release from the hospital.

From the psychologic point of view, the parents of a crippled child constitute a more serious problem for the orthopedic surgeon than the child himself. Even when intellectually convinced that the hospital is the proper place for his treatment, the parents continue to be ruled emotionally by the child's protests and wishes. It is particularly in trying to avoid being sent to a hospital that the child uses his unfortunate condition as a power device for controlling the situation. Here he has powerful allies in the feelings of the parents, who cannot endure the thought of separation or of arbitrary handling of their pet by doctors and hospital attendants. At this juncture, a statement by the physician of the psychology of the situation usually accomplishes little. The parents admit the truth of all that is said; but they are under the impression that their child is an exception, and they continue to be dominated by him.

We may say, then, that the psychology of the crippled child has a direct bearing on preventive orthopedic surgery, and is an important factor in the consideration of any measures for either private or institutional care of this most unfortunate group of patients. It is because the whim of a spoiled child may become a social menace that I bring this phase of the case so seriously to your attention.

30 North Michigan Avenue.

OBSERVATIONS ON THE FOUCHET TEST IN LATENT JAUNDICE

IN A SERIES OF ONE HUNDRED AND SIXTEEN PATIENTS

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During the last six months we have made observations on 500 patients. On each one, as part of our general routine, two tests have been made. One is a macroscopic test as to the presence of bile in the clear serum; the other is the Fouchet test as used to detect an increase of bilirubin in patients with so-called "latent jaundice." These tests have been made independent of each other, and without knowledge of other clinical findings.

The forty patients grouped under cholelithiasis and cholecystitis are those in whom the clinical, roentgenray and in some instances operative findings established the diagnosis beyond question. At the time of examination there was no visible jaundice, and tests for bile in the urine were negative. Twenty-seven patients showed a hyperbilirubinemia by the Fouchet test, and seventeen of these had a serum that was definitely bile tinged.

Hyperbilirubinemia with duodenal and gastric ulcer was present in sixteen patients. In no instance were findings referable to a diseased gallbladder present, although gallbladder involvement with duodenal ulcer frequently occurs.

In twenty-seven patients with syphilis who came under our observation, fourteen had a positive Fouchet test. A few of these had symptoms referable to the

gastro-intestinal tract, but these disappeared with antisyphilitic treatment.

A few persons who are undernourished and have a slight secondary anemia with no other pathologic findings often have a slight increase over normal in the bilirubin content of the serum.

In patients with other diseases, we find an increase in bilirubin content in angina pectoris, myocarditis, colitis, tuberculosis, asthma, etc., which we consider as added evidence that it does occur.

Results of Observations

Diagnosis	Case No.	Fouchet Test	Macroscopic, Bile in Serum	Bile in Urine	Visible Jaundice
Cholecystitis and cholelithiasis	17	Pos.	Pos.	Neg.	Neg.
Cholecystitis and cholelithiasis	10	Pos.	Neg.	Neg.	Neg.
Cholecystitis and cholelithiasis	13	Neg.	Neg.	Neg.	Neg.
Duodenal ulcer	5	Pos.	Pos.	Neg.	Neg.
Duodenal ulcer	9	Pos.	Neg.	Neg.	Neg.
Gastric ulcer	2	Pos.	Neg.	Neg.	Neg.
Cancer of the stomach	1	Pos.	Neg.	Neg.	Neg.
Chronic appendicitis	1	Pos.	Pos.	Neg.	Neg.
Diverticulitis of the sigmoid	1	Pos.	Neg.	Neg.	Neg.
Colitis	1	Pos.	Neg.	Neg.	Neg.
Secondary anemia	2	Pos.	Pos.	Neg.	Neg.
Secondary anemia	5	Pos.	Neg.	Neg.	Neg.
Pernicious anemia	4	Pos.	Pos.	Neg.	Neg.
Pulmonary tuberculosis	3	Pos.	Pos.	Neg.	Neg.
Pulmonary tuberculosis	1	Pos.	Neg.	Neg.	Neg.
Bronchial asthma	1	Pos.	Neg.	Neg.	Neg.
Hypertension	3	Pos.	Pos.	Neg.	Neg.
Chronic myocarditis	2	Pos.	Pos.	Neg.	Neg.
Chronic myocarditis	1	Pos.	Neg.	Neg.	Neg.
Angina pectoris	1	Pos.	Pos.	Neg.	Neg.
Angina pectoris	1	Pos.	Neg.	Neg.	Neg.
Chronic arthritis	2	Pos.	Neg.	Neg.	Neg.
Hyperthyroidism	2	Pos.	Neg.	Neg.	Neg.
Hypothyroidism	1	Pos.	Neg.	Neg.	Neg.
Syphilis	9	Pos.	Pos.	Neg.	Neg.
Syphilis	5	Pos.	Neg.	Neg.	Neg.
Syphilis	13	Neg.	Neg.	Neg.	Neg.

SUMMARY

Hyperbilirubinemia, as shown present by a positive Fouchet test, was found in 67 per cent. of patients with cholecystitis; 42 per cent. showed a positive macroscopic test for bile in the clear serum.

Hyperbilirubinemia is present in some patients with gastric and duodenal ulcer, syphilis, tuberculosis and other diseases.

Increase in the bile content in serum can in many instances be detected by a simple observation of the clear serum; it was noted in 52 per cent. of all cases who showed a positive Fouchet test.

800 Auditorium Building.

Combined Dietetic and Light Treatment in Rickets.—Experimental evidence having shown that one method by which exposure to light works is by stimulating to activity the fat-soluble vitamin supplies of the body, and since the only means of access of this substance is via the food, it would seem desirable, when making use of light therapy in the treatment of disease, that the diet should be controlled at the same time. This is also borne out by the fact that at least as regards bone calcification the influence of light can be completely antagonized by a defective diet. Whether exposure to ultraviolet rays enhances the calcifying influence of a very good diet still remains to be proved. I have treated rickets and many other pathological conditions by the combined therapy, but in no case has it been possible as yet to control the results by treating precisely similar cases only by diet or only by exposure to light. Cases of rickets respond well to the combined diet and light therapy, . . . but correct feeding alone also brings about rapid cure of this disease.—Edward Mellanby: Deficiency Diseases with Special Reference to Rickets, *Brit. M. J.*, May 24, 1924.

THE USE IN STERILITY OF ANTISPASMODIC DRUGS

IN COMBINATION WITH TRANSUTERINE INSUFFLATION OF GAS *

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For three years the transuterine insufflation of gas has been in most clinics a routine item in the investigation of sterility. It was introduced by Rubin for its diagnostic value in the question of tubal patency or occlusion, and has proved to be within certain limitations a most useful test.

If a pneumoperitoneum can be produced by the transuterine route, the patency of at least one tube is proved. If no gas can be insufflated into the peritoneal cavity through the uterus, then we must assume that both tubes are in some way occluded, and the presence of a tubal factor in the case under consideration is definitely established.

In a small group of patients, transuterine insufflation appears to have also a therapeutic value. Forty or more cases have been reported in which this procedure, undertaken for diagnostic purposes, was promptly followed by pregnancy, though no other treatment was given. Three such cases have occurred in my own practice.

Every one who has had much experience with insufflation has come to realize that no definite conclusions can be drawn from a single negative result. It often happens that a pneumoperitoneum is produced at the second, third or fourth attempt, after previous efforts have been unsuccessful. In the early days of the method, many of us made the mistake of operating on patients after one negative insufflation, only to discover tubes that were to all appearances entirely normal and were even permeable to a bristle. Doubtless there are some cases of this sort in which a positive result of insufflation is never obtained.

Clearly there must be a factor in these cases which, under certain conditions, prevents the passage of gas through the tubes, and under others has no such effect. It is hard to say whether this is a variable factor, present or absent in a case at different times and under different circumstances, or whether it is constantly present in such cases until a certain number of attempts at insufflation have been made, and is then permanently eliminated as a result of the insufflations. I am inclined to the former view, since on several occasions I have failed to produce a pneumoperitoneum in a patient who had previously been successfully insufflated.

The fact that a positive insufflation is sometimes followed by conception would indicate that the obstacle to the passage of gas, whatever it is, may also be an obstacle to the passage of spermatozoa through the tube. Repeated attempts at insufflation often result in the tubes becoming permeable to gas, and sometimes result in conception.

The question naturally arises what the nature of the tubal obstruction in these cases may be. Certainly there is no organic sealing, such as is commonly seen in old inflammatory lesions. Light adhesions, or the cohesion of sticky mucous surfaces, or congestion and edema are all possibilities, but none of them seems a particularly reasonable explanation of the phenomena observed.

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For some time I have felt that obstruction might be caused by spasmodic contraction of the circular musculature of the tube, particularly in the interstitial portion.

As the tube passes through the uterine wall, the circular fibers constitute what is practically a sphincter. In all probability, during life this sphincteric muscle keeps the uterine orifice of the tube lightly closed. We find in insufflating perfectly normal patients that the intra-uterine gas pressure must usually be raised to a point between 60 and 80 mm. of mercury before any gas enters the tubes; a sharp drop in pressure occurs as the uterine ends of the tubes are forced open.

The circular musculature undoubtedly relaxes to allow the passage of the fertilized ovum into the uterus, and in normal cases is never so tightly contracted as to prevent the penetration of spermatozoa into the tube.

Muscular spasm in the female pelvic organs is not an uncommon phenomenon. It is a prominent feature of certain types of dysmenorrhea, and has been thought at times to cause stenosis of the os internum of the uterus. From such instances of spasm in the uterus to the idea of spasm affecting the musculature of the interstitial portion of the tubes is no very far cry.

In cases having a tendency to muscular spasm, it would naturally be aggravated by the intra-uterine manipulations of insufflation, and also by the nervous stimulation of coitus. Hence, negative insufflations and sterility in such cases are reasonably explained as results of tubal occlusion by spasmodic contraction of the circular muscle.

The foregoing ideas have suggested that the administration of antispasmodic drugs previous to insufflation might make it possible to pass gas through tubes otherwise impermeable, and to transsufflate, at relatively low pressure, patients in whom a high pressure would otherwise be required.

I have followed this plan in five cases, with uniformly successful results. The drug used was benzyl benzoate, in the 20 per cent. alcoholic solution. In the first two cases, the dosage was 5 drops each hour for six hours before insufflation. Macht, in a personal communication, advises a larger dose, and in my last three cases the patients received 30 drops each hour for four hours.

REPORT OF CASES

CASE 1.—Mrs. K. had had four previous insufflations, two done by another physician and two by me. All had been negative, although a most careful technic was followed, and pressures up to 225 mm. of mercury were used. A laparotomy for the investigation of the tubal condition was under consideration. After six 5-minim doses of benzyl benzoate, gas passed through the tubes at a pressure of 100 mm., and a large pneumoperitoneum was produced.

CASE 2.—Mrs. P. had had one previous insufflation, which was negative. Six 5-minim doses of benzyl benzoate were given, and a second insufflation was done. The result was positive at a pressure of 80 mm.

CASE 3.—Mrs. P. had undergone four previous insufflations, the second doubtful and the other three negative. After four 30-drop doses of benzyl benzoate, a positive result was obtained at 70 mm. pressure.

CASE 4.—Mrs. McM. had undergone four previous insufflations, the first two, negative. In the last two, gas had been forced through the tubes at a pressure of 200 mm. Insufflation after four 30-drop doses of benzyl benzoate produced a pneumoperitoneum at a pressure of 60 mm.

CASE 5.—Mrs. A. had had two previous insufflations, with negative results. Four 30-drop doses of benzyl benzoate were given, and a positive result of insufflation was obtained at a pressure of 110 mm.

So it appears that spasm of the tubal musculature can undoubtedly be an obstacle to the passage of gas into the tubes. If we are correct in believing that such spasm may prevent also the entrance of spermatozoa, then sterility which is proved to be of this spasmodic type should be treated by the administration of antispasmodic drugs post coitum.

Spermatozoa deposited in the cervix may reach the uterine cornua within fifteen or twenty minutes. The action of benzyl benzoate is manifested in an even shorter time. I suggest that patients treated by the foregoing method take a large dose of benzyl benzoate, perhaps 60 drops of the 20 per cent. alcoholic solution, immediately after coitus, and then, in order to maintain relaxation, follow this with doses of 30 drops every hour for three doses, and every two hours for three more. As experience accumulates, we shall undoubtedly learn how to use smaller dosage in a more convenient way.

We have always encountered a considerable number of sterility cases in which the real cause, even after careful investigation, has remained obscure, and all treatment has been unavailing. It is to be hoped that a certain proportion of such cases can be successfully handled by the method here presented.

SUMMARY AND CONCLUSIONS

1. There is a definite group of sterile women through whose tubes gas can be passed with difficulty, or only after several attempts, or not at all, although the tubes are not sealed by adhesions, and are anatomically normal.

2. The factor that prevents the passage of the gas in such cases is probably spasm of the sphincter-like circular muscle of the interstitial portion of the tube.

3. The same factor can presumably prevent the entrance of spermatozoa into the tube, and so cause sterility.

4. It is most important to recognize cases of this type, and to distinguish them from cases of permanent occlusion by adhesions, in order that unnecessary operations for supposedly sealed tubes may be avoided, and in order that the real factor may be properly treated.

5. For the recognition of these cases, I propose the following test: A first insufflation is done without preliminary medication. If no gas can be made to pass through the tubes, or if gas passes only when the pressure has been raised to 150 mm. or more of mercury, a second insufflation is done a day or so later after the administration of benzyl benzoate. If, on the second occasion, gas passes through tubes previously impermeable, or if it passes at a pressure of less than 100 mm. of mercury in cases in which a high pressure was previously required, we can consider that an obstructive degree of spasm of the tubal musculature has been demonstrated as a factor in the case.

6. When it is shown by this test that a patient belongs to the group under discussion, and there is nothing else at fault with the wife or husband, then the administration of antispasmodic drugs post coitum is indicated for the treatment of sterility, and should give good results.

587 Beacon Street.

Deaths from Whooping Cough in Holland.—The deaths from whooping cough per hundred deaths in children under 14 years of age from all causes in Amsterdam in the decade 1907-1916 were 5.99 and for the whole of Holland 3.92. Per cent. of total under 1 year, 42.3; 1 to 4 years, 55.9; 5 years and over, 1.8; total, 100.—*Public Health Rep.* **38**:2775 (Nov. 23) 1923.

PSYCHOLOGY IN MEDICAL PRACTICE AND LEGISLATION

THE PROFESSION'S DUTY TO ITSELF AND TO THE NATION

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In 1921, the medical profession of New Jersey won the hardest fight of its history.

By united demand of all its members, it compelled the state to require chiropractors to possess some education, and it prevented the legislature from licensing insufficiently educated osteopaths to practice medicine and surgery.

The profession was stirred to action by the previous legislature's passage of a chiropractic law which omitted the mandatory educational requirements present in all previous licensing acts.

At this time (1920) the medical profession was held in such political contempt that the assembly refused it a hearing while the bill was under discussion. The resulting resentment was so general that, in answer to a call from the Welfare Committee, over one thousand physicians appeared at the state house at one time.

In the history of medicine, new cults have from time to time arisen, protests against the medical customs of the day; against the accepted routine of medical practice. Many of these protests have contained an element of truth—a truth overlooked by the rank and file of medicine in their busy lives of service. In a few instances these protests have grown to considerable proportions but later been absorbed into medicine itself; for medicine is not sectarian, medicine is catholic; it is eternal: it is truth.

In the last twenty years, two cults have engaged attention out of all proportion to their importance, osteopathy and chiropractic. Already one of them—osteopathy—is being absorbed into medicine; its votaries are now asking to be allowed to prescribe drugs and practice surgery.

Is there a germ of truth among their many patent absurdities? Is it a scientific revelation of great moment—as the discovery of anesthesia or the bacterial cause of disease? Were such the case the medical profession would hail the advance.

But it is not a great scientific truth which has been overlooked; nevertheless, their popularity and success are based on a psychologic fact that the medical profession has failed to appreciate properly.

The unwell man of today demands that something be done directly to the site of his discomfort; a mere diagnosis does not satisfy him. The age has become skeptical of the value of drugs: have we not, ourselves made it skeptical?

The public as well as the profession has discovered that colored nauseating fluids taken internally rarely have a selective action on pain or disability.

When the patient of today goes to a doctor, if the therapeutic attack is manifestly directed to the site of his pain, the patient is inclined to believe that something modern and scientific has been done for him. And what is more, something scientific has been done, although it may only be psychologic.

The osteopaths, with their "vertebral dislocations"—the chiropractors, with their "painless spinal adjustments," understand this and have commercialized it; while medical men, with their attentions focused on the scientific study of disease, have largely disregarded it. This shows a lack of understanding of the psychology of the patient necessary for his successful treatment, although the physician may understand fully the disease itself.

The profession should look the facts squarely in the face and decide whether the time has not come to treat systematically our patients, psychologically as well as medicinally. Should we not realize that in many diseases personal manipulation, massage, etc., of the patient is a good thing—for many headaches, for pains in the muscles and joints, even for the relief of the aches and pains of many of the acute infections?

All specialists utilize personal applications as far as they are of any real technical value. The orthopedists with their apparatus, massage and electric therapeutics, the rhinologists with their sprays, the aurists with their eustachian catheters, Politzer's bags and electric vibrators, and the eye men with their drops and ointments; but the general practitioner contents himself, on his rounds, with a prescription pad and a case of drugs, and a violet ray apparatus in his office. The importance of mechanical factors in pathologic conditions and psychologic states has not as yet reached his subconsciousness.

Again, are we not apt to be too careless about details apparently trivial but which, psychologically, may be of the greatest importance for success in treatment? We tell a patient, off-hand, to "take exercise." He does so for a day: but neglects it on the second: generally because it is inconvenient or bores him. If, however, a definite walk, at a definite time, to be followed by a prescribed meal, is ordered, and his imagination is enlisted by a weighing machine, a calory table and a little mathematics, he implicitly follows directions.

Naunheim cures decompensation by bathing and carefully regulated mountain exercises. Golf has cured more diseases of metabolism than drugs, but the cure is rarely assigned to the physician suggesting it, although always accorded to Naunheim; largely because of the doctor's failure to be specific, compelling the patient to discover for himself the exact time, degree and amount of play, and the associated diet and rest necessary for him to obtain the maximum benefit.

Lastly, have we not gone somewhat astray in our neglect, as formerly, in our use of drugs? Because so many diseases are self-limited, should we fail to try to relieve the distressing sore throat—the splitting headaches and the thousand and one aches and discomforts that are the chief complaints of sickness? Or—still worse—should we still persist in giving medication so nauseating or depressive that it is purposely omitted?

The wisest woman that I know—who "combines the wisdom and tolerance of an old woman with the spirit of a young girl"—believes in homeopathy, pure and simple. From bitter experience she knows that when she is sick and nauseated—and who is not nauseated when sick?—if an "allopath" is called he will, after a careful examination, either do nothing therapeutically, or else, worse still, prescribe medication liable to cause her additional digestive discomfort. When she sends for a homeopath he gives her two glasses of water, plus something which, whatever its medicinal properties, certainly does not spoil the water. If she were simply told to take small quantities of water at frequent intervals she would neglect it when not thirsty; but when instructed to take a teaspoonful from the first glass on the hour, and from the second ten

minutes later, her interest is stimulated, she regularly obtains the water that her economy demands in the small amounts that her digestive apparatus can care for, and is relieved.

But to say that the osteopaths and chiropractors have simply availed themselves of a psychologic fact will not account for the deluge of letters with which the legislators of many of our states are annually flooded—letters from judges, lawyers, .ministers and business men—all asking that these cults be given special privileges by legislative mandate without demanding of them the educational qualifications which the profession has erected to protect the public from incompetent medical practitioners. What explains this hold-up on the public imagination? The answer is, commercial publicity.

Our ethics forbids publicity to the physician, and rightly so. To permit a doctor to relate publicly his individual cures would be detrimental to the morals of the community and to the higher interests of the profession—but it would be advantageous to the doctor. Effectual commercial advertising was the subject stressed in the early osteopathic colleges: by it the chiropractors have obtained all their prominence.

In 1911, the osteopaths stated to our legislators that medical men were humbugs, drugs impotent, and surgery rarely necessary. Today having acquired, to their credit, a larger point of view, both scientifically and ethically, they advertise less and study more; while the chiropractors now call both the medical men and the osteopaths humbugs and adopt the latest commercial superlatives of publicity.

While we must continue to condemn individual advertising, we must not allow our ethics to prevent the proper use of publicity by the profession as a whole. We must develop channels to present our point of view and ideals to the public properly and with dignity, thus explaining that our insistence on standardized educational qualifications for all who would practice healing is solely for the protection of the public. The interest of the state, as well as of the profession, demands that there be inaugurated a definite plan of medical publicity.

In the campaign of 1921, the Medical Society of New Jersey organized politically the whole profession of the state; instructed groups to interview legislators; prepared public hearings and statements, bulletins and literature for the legislators, press, public and profession, to show what the medical profession was fighting for. This succeeded in repealing the obnoxious chiropractic law and the enactment of a proper "limited practice" act, and the following year prevented the reelection to the assembly of eight of the fifteen of the opponents of educational standards. Owing to lack of proper national organization, all this volunteer intellectual effort and labor—doctor's time,—has not been made available to the profession of other states. As the facts and methods of attack on educational standards are practically the same all over the country, this material should be copied, classified and filed, in the educational or legislative council of the American Medical Association, and copies placed at the disposal of legislative or welfare committees of any state, thus avoiding reduplication of effort and helping to consolidate the profession.

Skilfully conducted publicity of an injustice, real or imaginary, is always a powerful legislative weapon. The "medical trust" cry has uniformly been used to hide a lack of education. Legislators often fail to realize that a medical examination may be purely academic. It may or may not be a test of fitness to practice, depending on whether or not it is associated with proper experience, both technical and scientific.

The osteopaths state to the legislators that the two years of preliminary college education now demanded by our laws is not only unnecessary but was instituted by the profession for the express purpose of limiting the number of students and compelling them to attend certain prescribed colleges. In New Jersey there are a few osteopaths who are graduates of schools which are trying to give a fair degree of training in surgery and practice, and who have passed the state board's examination; the vast majority, however, have obtained licenses by registration or endorsement, without examination. They complain to our legislators that the state requires them to pass the board's examination, but does not allow them to practice surgery which, with the use of antiseptics, anesthetics and analgesics, is now their object.

The legislators' attention is thus adroitly focused on the similar examination but surgical restriction. The osteopathic colleges' low admission requirements, and their imperfect laboratory and clinical teaching facilities is thus disguised. The latter they would explain by accusing the profession of debarring them from practice in hospitals.

If the osteopathic colleges give an adequate medical and surgical training (both technical and scientific), we must not let any formula stand in the way of their proper recognition. As yet there is little evidence that they are so doing.

Up to the present the chief objection to all the osteopathic bills introduced into the legislature of New Jersey to extend their privileges is that, in spite of their verbiage, they would license groups of osteopaths whose educational qualifications do not in any way equal that required of medical men of similar date. Reduced to facts, they all aim to allow osteopaths to practice medicine by a short and easy educational road. By their enactment they would permit many incompetents, armed with the state's license, to practice surgery.

If we are to continue successfully to combat legislalative attacks, we must justly and scientifically reexamine our present educational standards, laws and methods in the light of experience, and, if found defective, inadequate or unjust, they must be revalued and altered to meet changed conditions of public needs, chief among which is the scarcity of physicians in the rural districts and the desirability of further restrictions before a license to practice major surgery is granted.

While we must refuse to lower our educational standards, it may be desirable that they be so modified that a man possessing the requisite knowledge and experience, no matter where obtained, may be allowed to practice, as in Massachusetts; or at least to enter a properly equipped medical college to supplement the knowledge he already possesses.

At the same time, our requirements as to experience and technical knowledge should be still further elevated. The advancement of surgery should make us inquire whether the license to practice major surgery should not be separated somewhat from that of physic, as in England, where a surgical license is only granted subsequently on the completion of an adequate amount of technical experience and knowledge.

Again, the profession as a whole must begin to think and act as technical public servants, not simply as individuals. The scientific progress of medicine is well known to the public, but it is time for the medical profession to realize that it collectively belongs to the public now, in peace as during the war; that we are a specialized part of the body politic, and, as such, must occupy a commanding place in those matters for which our education, experience and tradition qualify us alone —the public health.

When an educated man neglects his duties as a citizen, he commits the greatest public crime possible, except actual treason. For years the pulpit has taught that every man should vote. Of course, every man should vote; but voting is only a small part of our civic duty.

We live in a democracy. Democracy is the rule of the majority: but the majority is mediocre; consequently it has been said—and with truth—that democracy is the rule of the mediocre. Did not the draft astonish us by the extent of physical unfitness, and the high degree of illiteracy among our people?

The members of the medical profession are not mediocre. By their years of training, by their ethical standards, by the culture which has become theirs from years of research and thought, they are qualified to understand human needs: but in the pursuit of a scientific understanding of disease, in the very wonder and love of medicine they have, as a class, been led away from their larger duties as public citizens. Physicians must realize that they alone are qualified to supply to the nation that expert information which it must have.

I protest against the indifference of the individual physician and of the profession's organizations. It is our duty individually and collectively to speak in a commanding voice to the politicians in all matters that pertain to public health and its corollary, public education; for public education should be guided by the health, mental, physical and emotional, of the individual.

Equally important is this service to our country today with the scientific practice of medicine, because public health and education have become great national issues. A proper direction of public health will make us a greater nation—its neglect an enfeebled one.

We must demand that a physician be in the cabinet of the United States as secretary of a department of public health. We, as voters, must see that physicians are present in Congress and the national Senate; that in every state assembly and senate there is a certain proportion of physicians.

To this end we must make sacrifices; sacrifices of time and of practice. Democracy demands this sacrifice of each physician, as an educated man, if he would that democracy be continued.

One hundred years ago Helmholtz was born among a people whose men of learning were content to delegate to a few their political destiny; as long as it was successful. Today Germany is in the discard and its scientific men are paying the price not only for other criminality but of their own indifference.

In the very nature of our political institutions, the man of prejudice, with but little knowledge or scientific sympathy, must frequently occupy our legislation halls, as shown by the constant efforts to grant the privilege to treat disease without demanding an adequate education. Politically, the next few years are destined to be the most important in history. They will decide whether the world is to go forward or backward; there are movements in both directions. More than ever before, democracy demands that the educated man play his part in all public affairs; the medical man must be a leader in public health and educational movements. He can no longer afford to lead in the advance of medicine alone.

15 Lombardy Street.

THE EXERCISE CARDIAC FUNCTIONAL TEST IN ONE HUNDRED CASES OF HEART DISEASE

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It would seem that a fair judgment of the functional capacity of the heart could be arrived at by observing the response of that organ to exercise, for the physical activity of a healthy person is limited by the ability of his heart to increase its output; that is, to furnish an adequate supply of blood to the working muscles. If, then, an organically diseased heart is able to maintain the equilibrium of the circulation under conditions of stress, its functional capacity is normal. On the other hand, if such a heart does not respond to exercise by an increase in its working force, an efficient circulation is not maintained; hence, its functional capacity may be looked on as impaired.

The working force of the heart can be readily measured by a determination of the blood pressure. This fact has been seized on and made the basis of the exercise cardiac functional test. The test is performed by requiring the subject to undergo some sort of vigorous exercise. To quote Brittingham and White,[1] the "systolic pressure is then taken as soon as possible, usually within twenty-five seconds, and it is followed at from ten to fifteen second intervals until it is definitely dropping, then at thirty second intervals until it reaches within 6 mm. of the preexercise level of mercury. There is normally a sharp rise in systolic blood pressure within the first forty seconds after work, followed by a fall to within 6 mm. of normal within two minutes. If a healthy person continues to work until he has nearly reached his limit of capacity, the maximum systolic blood pressure will not be obtained until from sixty to eighty seconds after stopping work instead of the normal forty seconds, and the preexercise level will not be reached until the end of from three to six minutes instead of two. Such a curve is said to have a 'delayed rise' or 'delayed summit' and 'prolonged fall'." One would expect an organically diseased heart with impaired functional capacity to respond to work in the same manner that a normal heart responds to excessive exercise; that is, with a "delayed systolic rise" in the blood pressure or a "prolonged fall."

If this test could be shown to be reliable, it would be of inestimable service to one who attempts to make a prognosis of a case of chronic heart disease in which there are none of the early symptoms of failing compensation, such as precordial distress, dyspnea on exertion, or edema of the ankles.

In applying this test, I have used a body-bending exercise repeated twenty times in forty-five seconds, and have taken the blood pressure at the intervals suggested by Brittingham and White. I have observed not only the systolic, but also the diastolic blood pressure

1. Brittingham, H. H., and White, P. D.: Cardiac Functional Tests, J. A. M. A. 79: 1901 (Dec. 2) 1922.

variations and the changes in pulse rate before and after exercise. All of my subjects were males, ranging in age from 17 to 53 years. Among 100 men, there were sixty-six cases of mitral regurgitation, eight of mitral stenosis, fourteen of aortic regurgitation and twelve of combined valvular lesions. All were free from any evidence of heart failure at the time of the examination.

The results were at variance with those of the proponents of the test.[2] The blood pressure reaction of all of the subjects with mitral regurgitation was normal; that is, there was neither a delayed rise nor a prolonged fall in the systolic blood pressures. Moreover, the diastolic pressures during the test did not vary more than 4 mm. of mercury from the preexercise levels, in spite of the fact that seven men gave a history of decompensation at from two to five years prior to my examination. On the other hand, the time required for the pulse to return to the preexercise rate was definitely prolonged in 53 per cent. of the cases. Brady [3] believes that a pulse rate remaining more rapid than normal for over three minutes after fifteen deep knee flexions should arouse suspicion of the cardiovascular integrity. In thirty-five of my series of sixty-six cases of mitral regurgitation, the pulse did not return, after exercise, to the rate at rest for from four to fifteen minutes.

Two of the eight patients with mitral stenosis gave abnormal blood pressure reactions to exercise; one man, aged 48, showed a delayed rise in the systolic pressure, and one man, aged 42, reacted by a prolonged fall. There was no change in the diastolic pressures. In four instances, the pulse required more than four minutes to return to the initial rate.

Of the fourteen patients with aortic regurgitation, only one, a man of 53, gave a delayed rise in the systolic blood pressure. A tardy return of the pulse to normal after exercise was observed in half of the subjects.

The effect of exercise on the twelve men handicapped by combined valvular lesions was interesting. In every case the pulse rate remained more rapid than normal for more than four minutes following the twenty body-bending exercises. The average time required for the pulse to return to the preexercise level was eight minutes. In no instance was there a prolonged rise or a delayed fall in the systolic blood pressure.

COMMENT

Since only 3 per cent. of my series of cases with organic heart disease reacted to exercise by the so-called abnormal blood pressure response, this form of functional test can have little prognostic value. The blood pressure variations can be more satisfactorily explained as vasomotor rather than myocardial phenomena. I have observed a prolonged systolic fall in blood pressure following exercise in a number of persons with irritable heart, and in patients with whom asthenia was a prominent feature. In every instance, the interpretation rested on a vasomotor basis.

The tardy return of the pulse rate to the preexercise level is, however, constant enough in organic heart disease to entitle it to some consideration as a functional test of cardiac efficiency.

30 North Michigan Avenue.

2. Barringer, T. B., Jr.: Exercise Tolerance in Heart Disease, J. A. M. A. **79**: 2205 (Dec. 30) 1922.
3. Brady, William: The Anamnesis in Cardiovascular Disease, J. A. M. A. **70**: 1449 (May 18) 1918.

THE PRINCIPLES INVOLVED IN THE TREATMENT OF OBESITY *

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To be thin is fashionable. Likewise, if not carried too far, it is conducive to comfort and longevity.

It is not my purpose here to discuss the fatty dystrophies, such, for instance, as are believed to result from disease of the endocrine organs, but rather to confine myself to the treatment of ordinary obesity of moderate degree, the type which is best exemplified by that increase in weight which comes with the ease and contentment of middle age. It is this type which we encounter most often.

Does the metabolism of the obese patient proceed along lines identical with that of the normal person? Probably not. Yet, in the well known experiment of Rubner [1] on two brothers, one of them fat and the other thin, it was definitely shown that the basal metabolic rate, per square meter of body surface, was the same in the two. We must conclude, therefore, that if there is a difference it is in the pathway rather than in the amount of metabolic activity. Recent experiments by Strouse [2] suggest that the metabolism of the fat person does not react in the usual manner to the several foodstuffs; that, for instance, such a person tends to store rather than burn his fats, and that he does not experience from protein its usual specific dynamic action. It seems probable, however, that this applies to the excessively obese—to those who exemplify the so-called dystrophies—rather than to the moderately fat persons about whom I am speaking.

The obese person exercises too little, eats too much, or both. To cure him, the endeavor should be to balance the two main factors—metabolic activity and food intake—by stimulating the one and curtailing the other.

Regarding the first, the stimulation of metabolism, there are two effective physical means for accomplishing this end. First and foremost comes exercise. Exercise hastens materially the metabolic rate and leads to the increased oxidation of ingested food, or, if food is not available, then of body fat. The exercise should be of the right sort and should never be carried to the point of exhaustion. It should be mild and long continued rather than violent. It should be regular, not spasmodic, and if possible the patient should find in it interest and diversion. Exercise is the chief factor on which we must depend first and always for the stimulation of metabolism and for the oxidation of surplus fat.

The other useful physical stimulus is the cold bath. A cold shower or plunge greatly increases the metabolic rate, which increase persists for a long time afterward. Because its value is not fully appreciated and because the life of ease to which the fat person is often accustomed does not prepare him for the momentary punishment entailed in the cold bath, this procedure has been neglected. It has been said that patients who are more than 45 years of age do not stand this well; but if the heart is intact, the arteries not too sclerotic, and the blood pressure not too high, I doubt whether the cold bath does as much harm as continued obesity. An exception should be made, perhaps, of those people who genuinely do not react, and who feel chilly for several

* Read before the Section on Practice of Medicine at the Seventy-Fifth Annual Session of the American Medical Association, Chicago, June, 1924.

1. Rubner, quoted by Lusk: Science of Nutrition, Ed. 3, 1921, p. 256.
2. Strouse, Solomon: Communication to the Association of American Physicians, Atlantic City, May 6, 1924.

hours after the bath; but for the obese patient who reacts promptly, however disagreeable the shock, the cold morning bath is to be recommended.

Turning to the second chief factor, the curtailment of food—it should be emphasized that this must be accomplished along rational lines, with due regard for known metabolic laws. The cure will be more effective and harm will be avoided, if these laws are observed.

The first dietary consideration should be the total caloric intake. This should be relatively small, the exact figure depending on the weight desired and the rapidity of its contemplated attainment. The patient's ideal weight in kilograms should be estimated, and he should then be permitted as a rule an amount of food that will yield from 18 to 22 calories per kilogram.

The next consideration in the arrangement of this diet should be the preservation of nitrogen equilibrium. This is of paramount importance. The object here should be to force the patient to burn his own fat, and this without loss of body protein. This is not difficult to accomplish, for nitrogen equilibrium and carbon balance do not necessarily go hand in hand: the one can be preserved without the other. Lusk [3] has demonstrated that an animal, while conserving body protein, can be made to lose weight at the expense of body fat, provided the diet contains sufficient protein and is of low caloric value. Therefore, the first dietary principle of the treatment should be a menu which in caloric value is materially below the patient's needs, and yet which has a protein content abundantly equal to these needs.

This liberal quota of protein is recommended chiefly for the preservation of nitrogen equilibrium, but also because the specific dynamic action of this foodstuff is an effective aid toward securing increased metabolic activity. From 1.5 to 2 gm. of protein per kilogram of calculated ideal body weight can be regarded in the reduction cure as an appropriate amount.

I am aware of the work of Newberg and others which would indicate that an excessive protein intake is harmful to the kidneys; but the amount recommended here, liberal though it is, cannot be called excessive. No harm, under ordinary circumstances, can come from protein taken in this amount.

In addition to the amount of protein permitted, some consideration should be given also to its biologic value. In order to throw the smallest burden on the kidney and to preserve nitrogen balance in the most economical manner, the patient should choose proteins of high biologic value. These are proteins which supply to the organism in full measure all the aminoacids necessary to the building of the animal's own tissues. Chief among them are the proteins of meat, eggs and milk.

Turning to the carbohydrate quota of the diet, this foodstuff serves two important purposes. First, it is the chief source of energy for the maintenance of body temperature and, in overwhelming measure, for the production of work: and second, it is a most efficient protein sparer. To preserve nitrogen balance at an economical level, it has been shown that at least 50 per cent. of the energy contained in the food should come from carbohydrate. Fat will not serve the same purpose. It is clear, therefore, that the effort of many obese persons to avoid all starchy foods and to eschew all sweets is without reason. After computing the caloric value of the protein allowance, there should be added to the diet an amount of carbohydrate sufficient to bring its value almost or fully up to the desired total caloric intake.

3. Lusk: Science of Nutrition, Ed. 3, 1921, p. 154.

The precaution should be taken to see that this carbohydrate portion of the diet includes sufficient of the vitamin-carrying foods, such as fruits, tomatoes and the leafy portion of green vegetables. The need for vitamins in the reduction cure is sometimes forgotten.

With fats, the circumstances are different. Aside from considerations of appetite, this foodstuff finds a prominent place in the usual meal because of its high caloric value. For the obese person, however, this consideration no longer holds good, and fat is not a necessary part of the diet. Fat is the one foodstuff that in obesity we can afford to reduce to a minimum or, still better, omit altogether.

The other food factor to be considered is water. It can be stated with assurance that obesity is not increased by the excessive drinking of water, and that it is not relieved by abstention from water. In fact, the reverse may be true, for Hawk [4] has shown that water, in some small measure, acts as a stimulus to metabolism, which leads one to conclude that the liberal drinking of water is to be recommended. There is, however, one objection: the excessive drinking of water often induces the patient to eat more food. If this error is guarded against, an abundance of water should be advised.

There is yet another aspect of the diet which is seldom considered, but which is of extreme importance. It is the extent to which the food gives a sense of well-being and satisfaction, its satiety value, so called. Other things being equal, the patient should be allowed to eat the food which in largest measure allays his hunger and which gives him the greatest degree of satisfaction. Meat has the highest satiety value of all foods; it "sticks to the ribs" longest. Therefore, the protein that the patient receives should be largely in the form of meat. Since hard boiled eggs have a higher satiety value than soft boiled eggs, although the two are obviously of equal caloric value, the former should be preferred. Likewise, potatoes are preferable to bread, because in isodynamic quantities the former have a higher satiety value.

In this connection is seen the importance of sweets. A dessert taken at the end of the meal, as has been shown by Kestner,[5] will enhance greatly its satiety value. Not only are simple sweets, when credited with their proper caloric value, of no harm, but when taken at the proper time they will permit the patient to rest satisfied with a smaller quantity of food. If we would hold the patient down to a minimal intake and at the same time satisfy him, we should add always to the heavy meal a little dessert.

Short fasts are sometimes advisable. What are their influence on the metabolism of obesity? Starvation, even in the most obese, necessarily causes some loss of body protein, but what we fear most is that the abnormal destruction at this time of excessive amounts of fat may produce a surplus of fatty acids and lead to the condition known as acidosis. Abderhalden and Lampe [6] have shown, however, that repeated short fasts increase progressively the ability of the dog to split fatty acids, and Folin and Denis [7] have observed something similar in man. The last named investigators offer the assurance that repeated fasting in the obese is safe and effective, provided the extent of the acidosis is carefully watched.

Finally, a warning should be uttered against rapid reduction in weight. It imposes unusual hardship on

4. Hawk: Practical Physiological Chemistry, Ed. 6, Philadelphia, P. Blakiston's Son & Co., p. 993.
5. Kestner: Deutsch. med. Wchnschr. **45**: 285, 1919.
6. Abderhalden and Lampe: Ztschr. f. physiol. Chem. **78**: 398, 1912.
7. Folin and Denis: J. Biol. Chem. **21**: 183, 1915.

the patient, and in rare instances it may prove disastrous. A loss of from 3 to 6 pounds (1.4 to 2.7 kg.) a month, when continued sufficiently long, will obviously bring weight to any desired figure.

CONCLUSION

It is not necessary to resort to bizarre, freak diets in order to accomplish a reduction in weight. Nor, in the absence of definite thyroid deficiency, is the administration of thyroid extract or similar endocrine therapy necessary. Rational measures that follow known physiologic laws, consistently observed, are safer and, in the end, more effective.

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VISUAL DISTURBANCES PRODUCED BY TRYPARSAMIDE *

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The toxic phenomena observed in experimental animals following the administration of certain organic pentavalent arsenical compounds, such as atoxyl, arsacetin and tryparsamide, are largely centered in the central nervous system.[1] After large doses, animals develop tremors, incoordination of movements and, in some cases, clonic spasms. When atoxyl and arsacetin were first employed for the treatment of syphilis and trypanosomiasis in man, similar neurotoxic effects, especially characterized by damage to the optic nerve, were observed. A number of patients developed amblyopia and subsequent atrophy of the optic nerves following their use. Because the potential therapeutic value of these drugs was not commensurate with the gravity of this toxic manifestation, they were abandoned as syphilotherapeutic agents.

Tryparsamide, applied to the treatment of trypanosomiasis in man by Pearce,[2] also showed a tendency to produce visual disturbances. In her series of seventy-seven patients with trypanosomiasis, nine developed visual impairment. In three of these, there was some degree of permanent damage, while six patients recovered completely. When treatment was begun before the central nervous system had been invaded, there were no untoward visual phenomena. It was Pearce's impression that the chief factors concerned in this toxic action of the drug were dosage, the interval between the treatments, and the presence of advanced nervous system disease.

The first systematic study of tryparsamide in the treatment of syphilis was undertaken by Lorenz, Loevenhart and their co-workers[3] with special reference to neurosyphilis, and in this clinic.[4] Unlike atoxyl and arsacetin, the results of its use in neurosyphilis are so encouraging as to justify some risk of ocular damage, provided the risk can be shown to be relatively small, the use of the drug is limited to that class of patients in which potential therapeutic gain is commensurate with the risk, and some method of minimizing the danger is found.

In order to elaborate these points and to study the characteristics of visual impairment caused by tryparsamide, we have reviewed the series of patients treated in this clinic. Two hundred and forty-one patients have received more than 3,000 injections of tryparsamide. The drug is given intravenously, in courses of from eight to sixteen doses, the interval between doses being not less than one week. No other drug is used during the administration of tryparsamide, though mercury or arsphenamin is employed as interim treatment between the courses. The dose is usually between 30 and 50 mg. per kilogram (average adult dose, 3 gm.).

The visual disturbances fall into two general classes, which we have designated as subjective and objective reactions. The subjective type of reaction is without definite objective ocular findings or visual field changes when examined at the height of the reaction or at any other time. The type classed as objective constantly shows changes in the visual fields, and occasionally diminution of vision.

The gross incidence of untoward ocular symptoms in our 241 cases is 17.8 per cent. Twenty-four cases, or 10.2 per cent., fall in the subjective group; thirteen, or 5.5 per cent., in the group with objective ocular damage; and in five, or 2.1 per cent., the influence of tryparsamide is questionable. The questionable group includes three patients with some subjective complaints, in whom the mental condition was such as to make objective examination impossible, and two patients in whom incipient optic atrophy was accidentally discovered after a long series of tryparsamide injections. It was impossible to determine whether this optic atrophy was due to neurosyphilis or to tryparsamide therapy. In the subsequent discussion, this small questionable group will be disregarded.

SUBJECTIVE REACTIONS

The subjective type of reaction strongly suggests hyperesthesia of the retina as the underlying cause. The visual disturbances complained of by patients in this group are remarkably similar. From six to twenty-four hours after the injection of tryparsamide, a "dazzling" sensation appears, at times associated with a "tremor in the air." The sensation is constantly described as exactly similar to that produced by looking at snow under intense sunlight. In dim illuminations, these symptoms disappear or are greatly diminished, though in strong light they are increased. Their duration is inconstant, ranging from one or two days to two weeks.

From the ophthalmologic standpoint, there is no external change in the eyes and no diminution of vision. Muscular balance and accommodation are not affected. The media and fundi show no essential change, but in a few instances, a low grade hyperemia of the fundus is observed, without, however, any blurring of the neuroretinal margins or alteration in the physiologic cups. This hyperemia, if present, is always rather indefinite, does not appear to be of long duration, and often disappears within twenty-four hours. The visual fields and blind spots are identical with those recorded before

* This investigation has been partially supported by a grant from the Rockefeller Institute for Medical Research.

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1. Brown, W. H., and Pearce, Louise: Chemotherapy of Trypanosome and Spirochete Infections, I, The Toxic Action of N-Phenylglycineamide-p-Arsonic Acid, J. Exper. Med. **30**: 417 (Nov.) 1919. Fourneau, E.; Navarro-Martin, A., and M. and Mme. Tréfouel: Les dérivés de l'acide phenyl-arsinique (arsenic pentavalent) dans le traitement des trypanosomiases et des spirilloses expérimentales, Ann. de l'Inst. Pasteur **37**: 551 (June) 1923.

2. Pearce, Louise: Studies on the Treatment of Human Trypanosomiasis with Tryparsamide, J. Exper. Med. (supplement) **34**: 1 (Dec.) 1921.

3. Lorenz, W. F.; Loevenhart, A. S.; Bleckwenn, W. J., and Hodges, F. J.: The Therapeutic Use of Tryparsamide in Neurosyphilis, J. A. M. A. **80**: 1497 (May 26) 1923.

4. Moore, J. E.; Robinson, H. M., and Keidel, Albert: Tryparsamide in the Treatment of Syphilis, J. A. M. A. **82**: 528 (Feb. 16) 1924.

treatment. There are no scotomas, either absolute or relative. Case 1 illustrates typically the general type of reaction which we class as subjective.

CASE 1.—*Cerebrospinal Syphilis. Blurring of vision after fourth tryparsamide injection. No objective changes in eyes. Subsequent therapy without trouble.*

A white man, aged 51, with physical and serologic evidence of diffuse cerebrospinal syphilis, the clinical picture simulating multiple sclerosis, was treated with tryparsamide, the first injection being given, Oct. 12, 1923

On ophthalmologic examination before treatment, Oct. 9, 1923, the eyes externally were normal; the pupillary reactions were slightly sluggish but all were present. Extra-ocular movements were normal. The tension was normal. The corrected vision (low grade hyperopia) was 20/15 in each eye. Presbyopia was normal for the age. The muscular balance was normal. The media were clear. The right disk appeared slightly pale; the physiologic cup and neuroretinal borders were normal. The left disk appeared normal. In the peripheral fundus of the left eye were numerous punctate, atrophic areas of an old disseminated choroiditis. The visual fields were normal for form and color. The blind spots were normal in size. There were no scotomas.

November 15, the patient had received five weekly injections of tryparsamide, the average dose being 1.5 gm. (20 mg. per kilogram). The last injection of 1 gm. was given, November

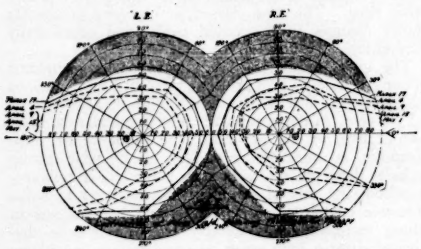

Fig. 1.—Contraction of form field following tryparsamide therapy in Case. 2.

8. On awaking the following morning, the patient noticed some dazzling of vision, and objects seemed slightly blurred until he looked at them intently, when he was sure he saw as well as formerly. There was no pain or other disturbance.

The examination of the eyes showed no change over the previous note. The corrected vision was still 20/15 in each eye; the fundi were unchanged. The visual fields were quite normal. The blind spots were normal in size. No scotomas could be demonstrated.

In the absence of objective findings indicating visual impairment, tryparsamide therapy was continued. To date, fourteen more injections, with an average dose of 31 mg. per kilogram, have been given, and there have been no further visual disturbances of any kind.

The eyes were examined last, April 4, 1924. The vision was still 20/15 each with correction. The fundi were unchanged. The visual fields were in every respect normal.

OBJECTIVE REACTIONS

In the type of reaction we have classed as objective, the same symptoms of dazzling vision are present. These symptoms are usually but not necessarily more intense than in the subjective group, and are accompanied by other changes which we believe to indicate definite organic damage to the eyes. The symptoms appear, as in the subjective group, about fifteen hours after the treatment with tryparsamide, and are usually accompanied by a slight dimness or veiling of vision. In this more intense type of reaction, patients constantly stated that objects in a dim illumination appeared gray.

On ophthalmologic examination, nothing is found externally, other than had been previously noted. Vision, however, frequently shows a slight but definite diminution. Muscular balance and amplitude of accommodation are unchanged. The fundi are usually normal, although occasionally the same hyperemia of the nerve head and retina, already referred to, is observed. The visual fields show a noteworthy alteration, consisting of concentric contraction of the form fields, affecting particularly the nasal, upper and lower fields, the temporal field being involved last or not at all. The color fields remain unaffected. We have never observed changes in the blind spots or scotomas of any type which could be attributed to the action of tryparsamide.

In a few of the more severe cases, visual failure and field contraction slowly increased to a maximum within three weeks, in every instance except one, however, stopping well short of blindness. The reaction progressed in this one patient, Case 4, on whom our records are not complete, to practically complete blindness, and, within a period of two months, there appeared advanced primary atrophy of the optic nerves. In all other patients in this group, the process either became stationary or improvement was noted, and some degree of useful vision was always preserved. The following cases illustrate various degrees of reaction with definite organic damage to the nervous tissues of the eye.

CASE 2.—*Asymptomatic neurosyphilis. Marked dazzling vision after third tryparsamide injection. Definite visual field changes.*

A white man, aged 32, with a functional psychosis, was discovered to have positive serologic changes in the spinal fluid. Tryparsamide therapy was begun, March 19, 1924.

On ophthalmologic examination before treatment, March 17, there was a slight anisocoria, the right pupil being larger than the left. The pupillary reactions to light were almost imperceptible. The reactions to accommodation were normally present. The tension was normal. The extra-ocular movements were all normal. The corrected vision (hyperopic astigmatism) was 20/15 in each eye. The accommodation was normal for the age. The muscular balance was normal. The media were clear, and the fundi appeared quite normal throughout. The disks were of good color; neuroretinal borders and physiologic cups were normally distinct. The visual fields were normal for form and color; the blind spots were normal in size. There were no scotomas.

April 4, the patient had received three weekly injections of tryparsamide, the last, of 3 gm., April 2. The average dose was 46 mg. per kilogram of body weight. On the morning of April 3, fifteen hours after the last injection, the patient had an attack of dazzling, increased by light, and described as a "tremor in the air." By night, objects appeared gray, as though there were mildew on them. The patient did not think there had been any actual visual failure.

Examination showed the anisocoria and almost absent pupillary reactions before noted. Otherwise the eyes were entirely negative externally. The corrected vision was 20/15 in each eye. The accommodation and the muscles were as before noted. The media were clear, and the fundi appeared entirely normal. The visual fields showed above, below and nasally, a contraction of approximately 15 degrees for form.

The color fields were unchanged. The central fields were normal; the blind spots were of normal size, and no scotomas were found. It was believed that some organic damage had taken place, and the tryparsamide therapy was discontinued.

April 9, there were no external or fundus changes, though the visual fields showed a further slight contraction. The symptoms of dazzling still continued.

April 15, the visual symptoms were still present, though of less degree. The visual fields were essentially the same as at the last examination.

May 1, the symptoms had entirely disappeared. The eyes showed no change to external or ophthalmoscopic examination.

The corrected vision was 20/15 in each eye. The visual fields showed exactly the same condition before noted. The process appeared stationary.

CASE 3.—*General paralysis. Marked visual disturbance and permanent constriction of visual fields after tryparsamide.*

A white man, aged 35, had been treated elsewhere for syphilis for three years. In February, 1924, the physical, mental and serologic changes of general paralysis were discovered. Tryparsamide therapy was instituted, Feb. 9, 1924.

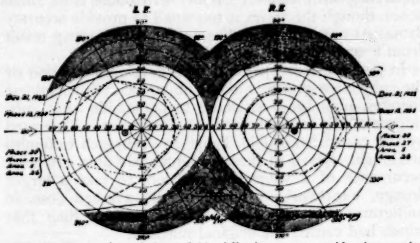

Fig. 2.—Contraction of form fields following tryparsamide therapy in Case. 3.

On ophthalmologic examination before treatment, Dec. 21, 1923, the eyes were externally negative. The tension, the pupillary reactions, and the extra-ocular movements were all normal. The corrected vision (low grade of myopic astigmatism) was 20/15 in each eye. The media were clear, and the fundi were entirely normal. The visual fields were normal for form and color. The blind spots were normal in size. There were no demonstrable scotomas.

March 12, 1924, the patient had four injections of tryparsamide. The morning after the first injection of 2 gm., he complained of slight blurring of vision on reading. In spite of this, February 16, an injection of 2.5 gm., and February 25, one of 3 gm. were administered. After each of these, the blurring and dazzling of vision were slightly intensified. The last injection of 2 gm. was given, March 5. The average dose was 39 mg. per kilogram. About fifteen hours after the last treatment, the patient complained of "snow blindness" and definitely increased blurring in vision, especially noticeable in dim lights.

The eyes externally were entirely negative. The corrected vision was 20/20 in the right eye, and 20/30 plus in the left eye. The accommodation and the muscles were unaffected. The media were clear. The fundi were definitely hyperemic, especially the left nerve head, but showed no other abnormalities. The visual fields showed a sharp contraction, varying from 10 to 30 degrees, more marked nasally, above and below. The central fields were normal; the blind spots were of normal size. There were no demonstrable scotomas. The color fields were unchanged.

It was felt that definite organic damage had probably occurred, and the tryparsamide therapy was discontinued.

March 20, the symptoms of dazzling and dimness of vision had cleared considerably. The eyes were negative externally. The corrected vision had risen to 20/15 in each eye. The media were clear, and the fundi appeared normal. There was no hyperemia. The visual fields were unchanged in the right eye. In the left eye, there had been a slight extension of the field temporally. The central fields were still entirely normal.

March 27, the visual symptoms had entirely cleared, but the patient was quite conscious of the limitation of the visual fields. The examination of the eyes was as last noted. There had been no further change in the visual fields.

April 5, the condition appeared entirely stationary. The vision remained 20/15 in each eye. The media and the fundi were normal. The visual fields showed the same contraction.

April 26, after injections of tryparsamide on the 12th and the 19th, there were no subjective reaction in the eyes. Examination showed exactly the same picture as noted on the last examination. There had been no further change in the visual fields. The patient was conscious of the field limitation, but was quite able to work at his occupation requiring accurate central vision. Tryparsamide therapy was permanently discontinued.

It should be noted in this instance that, had the warning provided by the subjective visual disturbances after the first few injections prompted earlier ophthalmologic study, permanent visual damage of this extent might have been avoided.

CASE 4.—*General paralytic neurosyphilis. Complete blindness after tryparsamide.*

A white man, aged 42, suddenly developed a grandiose general paralytic psychosis after a single combined intravenous and intraspinal treatment of arsphenamin, given, May 11-12, 1923. For this reason tryparsamide therapy was instituted, May 19. His eyes had not been previously examined by an ophthalmologist; but visual acuity was subjectively normal, and the fundi, examined, March 22, 1923, by an eminent internist, and, May 2, by one of us (J. E. M.), were considered to be normal. There was at least no outspoken evidence of preexising optic atrophy.

Between May 19 and July 7, he was given seven injections of tryparsamide, the total dose being 29 gm., and the average dose 58 mg. per kilogram. After each injection of the drug, he was carefully questioned as to subjective visual disturbances. Owing to his euphoric, expansive, grandiose mental condition, his invariable reply was that he could see perfectly well. July 7, however, it was noted that he was having difficulty in finding his way about a slightly darkened room, especially on coming into it from bright sunlight. An ophthalmologic examination was therefore made, July 18. It must be remembered that there was never any complaint of subjective visual impairment.

The ophthalmologic examination showed slight anisocoria, the right pupil being a shade larger than the left. The pupillary reactions were very feeble, the right direct light reaction being stronger than the left. The consensual reaction was doubtful. The convergence reaction could not be determined. The vision with both eyes was not over 10/200. Lack of cooperation due to the confused and grandiose mental condition made it impossible to test the individual eyes. The media were clear. Both disks showed a picture of well advanced primary atrophy. There was a small patch of atrophic choroiditis near the right fovea; otherwise the peripheral fundi appeared normal.

TABLE 1.—*Time of Occurrence of Ocular Disturbances*

Number of Dose After Which Disturbance Began	Subjective	Objective	Total	Total Number of Patients Receiving This Many Injections of the Drug
1	..	1	1	...
2	2	4	6	...
3	5	4	9	...
4	3	2	5	...
5	4	3	7	...
6	1	..	1	...
7	..	..	..	...
8	1	..	1	...
9	..	..	..	...
10	2	..	2	...
1-5	14	14	28	241
6-10	5	..	5	173
11-15	..	..	..	113
16-20	2	..	2	75
21-25	..	..	..	47
26-30	..	..	..	23
31-35	..	..	..	15
35+	..	..	..	11

September 9, there was a faint pupillary reaction in each eye, slight anisocoria, and advanced primary atrophy of both optic nerves. The patient appeared entirely blind.

Since that date, the patient has been repeatedly examined. May 8, 1924, he had no demonstrable vision, and presented the picture of advanced primary atrophy of the optic nerves.

In this instance, it is impossible to determine when the damage to the optic nerve took place. The patient was not in a mental condition to give reliable informa-

tion as to the state of his vision. Had it been possible to detect early signs of visual impairment, the severe injury might have been avoided.

Instead of the gradual course of increasing field constriction, which, if it progresses far enough, leads to ultimate visual failure, visual damage from tryparsamide may assume a more acute form. We have seen two patients, and have information of a third, in whom almost complete loss of sight suddenly developed within from one to four days after one or several injections of the drug. In each of these instances, however, the amblyopia gradually cleared up in from two to four weeks, leaving practically normal vision. One of these patients, a youth with lymphosarcoma, became unable to recognize large objects, though light perception was retained, within forty-eight hours after a single injection of 1 gm. Four days later, however, he was able to count fingers, and at the end of three weeks his vision was apparently normal. A second patient with general paralysis developed complete blindness two days after the third injection of the drug (average dose 56 mg. per kilogram). This amblyopia persisted for two weeks, when he regained light perception. A week later, he was able to recognize individuals, and improvement has continued until at present, four months after the accident, he has regained useful vision. The principal remaining defect consists of inability to see well when he moves from sunlight into shadows, or vice versa. Unfortunately, our records of these patients are incomplete, and we are unable to present data as to visual acuity and visual fields before or after treatment.

TABLE 2.—*Relation of Ocular Disturbances to Average Dose in Milligrams Per Kilogram of Body Weight*

Average Dose, Mg. per Kg.	Total Patients	Number Developing Ocular Disturbances	Per Cent. of Incidence	Ocular Disturbance: Subjective Cases	Subjective %	Objective Cases	Objective %	Questionable Cases	Questionable %
11 to 20	17	5	29.4	2	11.7	2	11.7	1	5.8
21 to 30	44	9	20.4	4	9.0	2	4.5	3	6.8
31 to 40	73	14	19.1	8	10.9	5	6.8	1	1.3
41 to 50	63	8	12.7	6	9.5	2	3.1	..	....
51 to 60	23	4	17.4	1	4.3	3	13.0	..	....
61 to 70	3	..	....	..	....	..	....	..	....
71 to 83	2	..	....	..	....	..	....	..	....

ANALYSIS OF FACTORS BEARING ON VISUAL IMPAIRMENT

The principal field of usefulness for tryparsamide is in the treatment of neurosyphilis, which provides the majority of the cases under consideration in this paper. Before proceeding with an analysis of the factors surrounding the untoward visual effects of the drug, it must be noted that optic atrophy is prone to occur in untreated neurosyphilis, or in spite of treatment, especially in general paralysis, taboparalysis and tabes. The incidence and severity of optic injury following the use of tryparsamide are, therefore, to be considered from the point of view of the incidence and severity of such lesions in patients untreated, or treated by other methods.

It is a point of importance that 80 per cent. of all visual reactions have occurred, as shown in Table 1, by the fifth dose of the drug; and 94 per cent. by the tenth dose. If a patient can be given as many as five doses of tryparsamide without visual disturbance, an indefinite amount of the drug may usually be administered. This increased liability to reaction early in the course of treatment necessitates careful surveillance.

Much to our surprise, there seems to be no direct relationship between the amount of the drug given and the incidence of visual disturbances. Our experience on this point is summed up in Table 2. Within certain limits, visual disturbances seem as likely to appear after small doses, expressed in terms of milligrams per kilogram of body weight, as after the largest doses that we have administered. Indeed, in our cases there is apparently an increased liability to trouble from small doses, though the series is too small to provide accurate data. At any rate, objective ocular damage may result from a small dose of the drug.

In general, those patients who develop a reaction of the subjective group, without objective ophthalmologic changes, may be given more tryparsamide after subsidence of the original reaction. This point is illustrated by the cases detailed in Table 3. Ten such examples are given. Seven of these patients were able, after the occurrence of a subjective reaction, to take a larger dosage, expressed in terms of the average dose in milligrams per kilogram of body weight, than that which had caused the original reaction.

In the first paper on tryparsamide published from this clinic,[4] the statement was made that "we have not seen an instance of visual disturbance in early or late syphilis without involvement of the nervous system." In Table 4, we present a summary of the incidence of untoward visual accidents in relation to the various types of disease treated. Though the majority of reactions occur in patients with neurosyphilis, we have now observed six instances of ocular damage in patients without neurosyphilis. Three of these were late syphilitics with no clinical or serologic evidence of invasion of the nervous system. Two patients, both nonsyphilitic, with postencephalitic parkinsonian syndromes, developed mild subjective reactions; and a nonsyphilitic boy with lymphosarcoma developed a transitory high degree of visual impairment. In the neurosyphilitic group, general paralytics and tabetics seem especially prone to ocular reactions. Of eighty-three general paralytics and tabetics, nineteen, or 22.8 per cent. (excluding questionable reactions), developed some degree of visual impairment, while of eighty-five patients with other types of neurosyphilis, only thirteen, or 15.2 per cent., developed trouble. This is in keeping with the incidence of visual impairment in untreated neurosyphilitic patients.

That nervous system disease in general is a predisposing factor to visual disturbances is emphasized by a

TABLE 3.—*Amount of Drug Producing Subjective Visual Disturbance, and Course Under Subsequent Treatment, in Individual Cases* *

Subjective Disturbance Occurred After: Number of Dose	Total Dose Given up to This Point, Gm.	Average Dose, Mg. per Kg.	Subsequent Treatment with Tryparsamide: Doses	Total Dose, Gm.	Average Dose, Mg. per Kg.	Ocular Disturbance
4	6.5	21	12	27.5	30	None
4	11.0	39	8	24.0	42	None
20	31.5	27	14	40.0	50	None
6	11.5	27	5	10.0	28	None
5	16.0	28	22	58.0	37	None
10	15.0	23	14	40.5	46	None
15	27.0	30	4	12.0	50	None
3	5.0	28	7	7.0	17	None
5	16.0	53	7	25.0	59	None
10	30.0	45	9	27.0	45	None

* In addition, four patients with subjective complaints of visual difficulty but not objective ophthalmologic changes were treated continuously, in spite of the visual disturbance. This did not increase, and disappeared when the drug was finally stopped.

rearrangement of these data, as shown in Table 5. In sixty-five patients, in whom central nervous system disease could be excluded, the incidence of untoward visual phenomena was but 6.1 per cent., while in neurosyphilis and postencephalitic parkinsonian disease, these accidents occurred in 21.1 per cent. of 180 cases.

The fact that several early ocular reactions arose in patients with preexisting syphilitic eye disease led us, in our first paper, to consider syphilitic involvement of the optic nerve or retina as an absolute contraindication to the use of tryparsamide. In the light of additional experience, this is, we believe, unnecessary caution. In our series, there are 110 patients whose eyes were examined before and during the treatment by a competent ophthalmologist, and in whom accurate records of the objective condition of the eyes, visual acuity and visual fields were kept. In ninety-five (Table 6), there was complete absence of any preexisting ocular lesion, the eyes appearing in every respect normal. Following tryparsamide therapy, twenty of these patients, or 21 per cent. (excluding questionable reactions), developed visual disturbances. The remaining fifteen patients showed definite preexisting syphilitic lesions of the eyes, and in twelve of these the optic nerve was involved. Visual disturbances occurred in four, or 33 per cent., of these twelve patients. Contrary to our early opinion, it is possible, therefore, to administer tryparsamide to patients with preexisting syphilitic eye disease, though we emphasize the necessity for careful ophthalmologic control in such cases. The facts that visual disturbances may arise in patients with normal eyes, and that they may fail to develop in patients with outspoken syphilitic eye disease point toward direct toxic action of the drug on the retina or optic nerve as a factor in their causation.

Yet this toxic action of tryparsamide is an inconstant and unpredictable phenomenon. We have administered large amounts of the drug to many patients, who have been most carefully followed from the ophthalmologic standpoint, and, despite such intensive therapy, we have observed no ocular reaction of any kind. Table 7 illustrates ten such cases from our series.

The ultimate outcome of visual disturbances in our patients may be briefly summarized: All the twenty-one patients with subjective reactions now have normal vision. Of the thirteen patients with objective reaction, three recovered completely with normal vision and visual fields. Three retained normal central vision, but are left with slight concentric contraction of the visual fields. In five, there remained at the last examination definite diminution of visual acuity; but in each instance useful vision, at least 20/30 in the better eye, was still present. One patient showed a more serious impairment, the better eye having only 20/80 vision. One patient only is blind (Case 4). In seven of the thirteen patients, therefore, residual damage is moderate or severe in degree, while six were injured slightly or not at all. The incidence of noteworthy permanent visual injury is thus 2.8 per cent. in our 241 cases.

This represents, we believe, an almost irreducible minimum of visual impairment from tryparsamide. We have studied our cases carefully to determine whether visual impairment might have been prevented had additional precautions or safeguards been employed. In only two instances (Cases 3 and 4, cited above), might objective injury have been avoided. In one of these, preliminary warnings of blurred and dazzling vision were disregarded; in the other, the mental condition was too fogged to provide subjective warning. In the remaining eleven patients with objective reactions, visual injury occurred simultaneously with the appearance of symptoms.

The outcome in our patients, however, makes it probable that severe permanent visual damage may be largely prevented. Ophthalmologic examination must be carried out at the first appearance of subjective disturbances, and visual acuity and fields compared with those noted before treatment. At this point, objective injury, if present, is usually so slight as to leave useful vision, if the drug is permanently withdrawn. Treatment of patients whose mental condition is too dilapidated for cooperation, or the continuation of therapy after changes in visual acuity or fields have occurred, is fraught with grave danger.

TABLE 4.—*Incidence of Ocular Disturbances in Relation to Type of Disease*

Type of Disease	Number of Patients Treated	Total Number of Cases With Untoward Ocular Symptoms	Per Cent. of Incidence	Ocular Disturbance: Subjective		Objective		Questionable	
				Cases	Per Cent.	Cases	Per Cent.	Cases	Per Cent.
Early syphilis	10	..	....	..	....	..	....	..	....
Latent syphilis without central nervous system involvement	45	3	6.6	2	4.4	1	2.2	..	....
Neurosyphilis:									
General paralysis	38	8	21.0	2	5.2	5	13.1	1	2.6
Taboparalysis	4	1	25.0	..	....	..	....	1	25.0
Tabes	41	13	31.7	9	21.9	3	7.3	1	2.4
Meningovascular	43	10	23.2	6	13.9	3	6.9	1	2.3
Vascular	5	..	....	..	....	..	....	..	....
Asymptomatic, late	27	3	11.1	3	11.1	..	....	..	....
Early neurosyphilis	10	1	10.0	1	10.0	..	....	..	....
Complete optic atrophy	4	..	....	..	....	..	....	..	....
Nonsyphilitic	12	3	25.0	1	8.3	1	8.3	1	8.3
	235*	42	17.8	24	10.2	13	5.5	5	2.1

* Excluding patients completely blind before treatment.

TABLE 5.—*Effect of Central Nervous System Disease on Incidence of Ocular Disturbances from Tryparsamide*

Type of Disease	Number of Patients Treated	Total Number of Cases with Ocular Symptoms	Per Cent. of Incidence	Ocular Disturbance: Subjective		Objective		Questionable	
				Cases	Per Cent.	Cases	Per Cent.	Cases	Per Cent.
No Central Nervous System Disease									
Syphilis, early and late	55	3	5.4	2	3.6	1	1.8	..	....
Nonsyphilitic	10	1	10.0	..	....	1	10.0	..	....
Total	65	4	6.1	2	3.0	2	3.0	..	....
Central Nervous System Disease									
Neurosyphilis, all types	178*	36	20.2	21	11.7	11	6.1	4	2.2
Epidemic encephalitis	2	2	100.0	1	50.0	..	....	1	50.0
Total	180	38	21.1	22	12.2	11	6.1	5	2.7

* Excluding patients completely blind before treatment.

COMMENT

The clinical picture of atoxyl and arsacetin amblyopia consists of gradual visual failure and constriction of the visual fields, at first without ophthalmoscopic changes, but later with the development of primary optic atrophy. In the main, all observers have emphasized

that there are no scotomas and that the papillomacular bundle is not affected out of proportion to the balance of the nerve. The pathologic lesions have been studied by Birch-Hirschfeld,[5] Igersheimer,[6] Sattler,[7] Key [8] and others. These investigators agree that the chief action of these compounds is on the peripheral portion of the third optic neuron, although the ganglion cells of the retina, or the axis cylinder of the third optic neuron may be attacked. Birch-Hirschfeld [5] believes that

TABLE 6.—*Unpredictable Nature of Visual Disturbances from Tryparsamide*

Condition of Eyes	Total Number of Cases	Cases with Untoward Ocular Symptoms	Per Cent. Incidence	Ocular Disturbance		
				Subjective	Objective	Questionable
Vision, fields and fundi normal	95	22	23.2	15	5	2
Preexisting Syphilitic Eye Disease						
Incipient primary optic atrophy	4	2	....	1	1	..
Doubtful primary optic atrophy	5	1	....	1	..	..
Neuroretinitis	3	2	....	1	..	1
Interstitial keratitis	2	..	....	..	..	..
Kerato-iritis	1	..	....	..	..	..
Total	15	5	33.3	3	1	1

atoxyl has an especial affinity for the rods, and leaves the cones relatively unaffected. A noteworthy feature of atoxyl and arsacetin amblyopia is that when visual failure and field constriction have begun, withdrawal of the drug has little or no effect on the progress of the reaction, the optic atrophy steadily progressing to complete blindness.

Unlike the action of these two drugs on the optic nerve is that of a French proprietary said to be sodium benzosulphoaminophenylarsenate.[9] Visual disturbances of a transitory nature apparently followed the administration of this drug, clearing within twenty-four hours, recurring again if the drug was again administered, and disappearing completely without residual damage when the drug was withdrawn.

The clinical effect of tryparsamide on the eyes presents a picture between that of this French proprietary and that of atoxyl and arsacetin. Tryparsamide may cause subjective visual disturbances without organic damage, clearing spontaneously on withdrawal of the drug. Or, definite damage may occur leading to visual failure, concentric contraction of the fields, and, in one case at least, to complete primary optic atrophy. But unlike the action of atoxyl and arsacetin, the first appearance of organic damage does not indicate the onset of a hopeless and progressive optic atrophy. Withdrawal of the drug at this stage is followed by the arrest of both the visual symptoms and the organic disturbance.

As a result of our experience with tryparsamide thus far, we have adopted the following method of guarding against untoward visual accidents: Before the commencement of tryparsamide therapy, the eyes of the patient are carefully examined. Any organic defects, visual acuity with refraction correction, and visual fields are accurately recorded. The patient is then warned to report visual disturbances of any kind. If these occur, the eyes are immediately reexamined. If no change in the visual acuity or visual fields is noted, tryparsamide therapy is usually continued. If, however, any failure of central vision, and especially any contraction of the visual fields, is present, the drug is immediately withdrawn. By this means, we believe it possible to use tryparsamide with relative safety, and to reduce to a minimum damage to the vision or the nervous tissues of the eye.

When such an important function as vision is involved even slightly, however, the use of a drug should be limited to that class of patients in whom some risk is justified by an appropriate therapeutic gain. The field of usefulness of tryparsamide lies, so far as we now know, in the treatment of trypanosomiasis and of neurosyphilis.[10] In these conditions, both with an otherwise relatively poor prognosis, the therapeutic results of its use are distinctly encouraging. In patients with syphilitic manifestations elsewhere than in the nervous system, on the other hand, the drug is not as efficacious as the arsphenamins, and, in view of the gravity of possible visual damage, it should not be used. In other conditions, such as encephalitis, anemias, and malnutrition, in which the drug has so far been cautiously tried, there is no positive evidence of its value; and we believe that the risk of visual damage is too great to justify its further trial. For the present, at least, the general use of tryparsamide ought to be strictly confined to trypanosomiasis and neurosyphilis.[11]

SUMMARY

1. Visual disturbances produced by tryparsamide may be divided into the classes of subjective and objective. The symptoms of dim or dazzling vision are common to each class. In the subjective group, ophthalmologic examination gives negative results. In the objective group, the striking ophthalmologic change is constriction of the visual fields for form, without scotomas, and with or without diminution in the visual acuity.

2. In patients with reactions of the subjective type only, it is usually possible to administer more tryparsamide without further difficulty.

3. If objective evidence of visual damage is present, the drug should be permanently withheld.

4. Among 241 patients, who have received more than 3,000 injections of tryparsamide, 10.2 per cent. have

TABLE 7.—*Individual Cases Showing that Large Amounts of Tryparsamide May Be Given Without Ocular Damage*

Diagnosis	Tryparsamide: Total Number of Doses	Tryparsamide: Total Dose, Gm.	Tryparsamide: Average Dose, Mg. per Kg. Body Weight	Condition of Eyes: Before Treatment	Condition of Eyes: After Treatment
Central nervous system meningovascular	19	46.5	37	Optic neuritis	Cleared up; eyes normal
General paralysis	20	57.5	40	Incipient optic atrophy	No change
Central nervous system meningovascular	22	53.0	30	Normal	Normal
General paralysis	20	59.0	44	Incipient optic atrophy	No change
Tabes	21	47.0	42	Normal	Normal
General paralysis	39	86.1	43	Normal	Normal
Asymptomatic central nervous system	38	90.0	34	Normal	Normal
Tabes	32	84.5	43	Normal	Normal
Tabes	37	90.0	39	Normal	Normal
General paralysis	42	94.0	34	Normal	Normal

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developed reactions of the subjective group, and 5.5 per cent. the objective type of visual disturbance.

5. Ninety-four per cent. of all reactions occurred early in the course of the treatment, by the time of the tenth injection.

6. Visual disturbances bear no direct relationship, within certain limits, to the dose of the drug administered.

7. Disease of the central nervous system, especially general paralytic and tabetic neurosyphilis, is to some extent a predisposing factor to visual disturbance from tryparsamide.

8. Preexisting syphilitic disease of the optic nerve or retina is not necessarily a contraindication to the use of tryparsamide.

9. It is probable that the drug exercises, in some instances, a direct toxic action on the retina or the optic nerve.

10. Before beginning tryparsamide therapy, every patient should be examined by a competent ophthalmologist as to visual acuity, fundi and visual fields. The occurrence of any visual disturbance must form the occasion for a second examination.

11. In the present status of our knowledge of the drug, its use should be strictly limited to the treatment of trypanosomiasis and of neurosyphilis.

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STUDIES ON THE METABOLISM OF OBESITY

PRELIMINARY REPORT *

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It seems rather unfortunate that the interesting problem of obesity has been befogged by the niceties of endocrine terminology, for attempts at elucidating the underlying metabolic anomaly of obesity cannot rest satisfied with names. It is perfectly true that diseases of certain endocrine organs, notably the thyroid, hypophysis and sex glands, are associated with symptom complexes embracing obesity, yet up to the present time it is extremely doubtful whether any exact metabolic explanation has been made of the concomitant obesity except in hypothyroidism, where a lowered basal metabolism exists. In other instances of endocrine disease, changes in the metabolism are inconsistently found, but neither theory nor ascertained fact has conclusively eliminated the thyroid as an etiologic agent in the obesity. Some of the anatomic localizations of fat deposits that have been described as pathognomonic of disturbances of special glands are of more interest from the standpoint of clinical speculation than of proved metabolic fact.

When we started our studies four years ago, obesity cases were generally divided into four groups: (1) obesity due to overeating or underexercise; (2) obesity due to thyroid deficiency; (3) obesity associated with disturbances of other ductless glands, and (4) obesity of unknown etiology, the so-called "constitutional" obesity. Studies of the metabolism up to 1907 were comparatively few, and according to von Noorden, not exempt from criticism because of faulty technic. Means, in 1915, expressed the opinion that there was no characteristic change in basal metabolism in obesity, an opinion that has been fully verified by subsequent work. Isolated and, on the whole, unsatisfactory studies of the effect of food were published, with no concordant results.

It seemed to us that, to acquire a real insight into the anomalies of metabolism in obesity, it would be necessary to inquire into the total day's activity of obese persons. This would include the effect of food and of exercise on the metabolism. In addition to studying the effect of food and exercise on total metabolism, it seemed necessary to obtain information on the sources of energy; in other words, to study the proportions of protein, fat and carbohydrate oxidized to form the total metabolism.

We first studied the caloric intake of some obese persons, and by carefully controlled dietary experiments in the hospital and the home we were able to prove that some obese persons maintained their body weight on diets far below their calculated caloric requirements. The details of this work will be reported elsewhere.

Our next object was to study the effect of various foods on obese persons and to compare these results with identical experiments on normal and thin persons. In this work we purposely avoided endocrine labels; our cases were selected merely on the basis of percentage deviation from calculated normal weight, and no correlation between clinical pictures and metabolism was made until after the metabolism studies were completed and recorded. Our normal and thin controls were all healthy persons. Our subjects varied from 30 per cent. underweight to 140 per cent. overweight.

The technic was standard throughout. In most instances the subject was given a trial day in the apparatus to accustom him to the procedure. The following day, after basal metabolism readings were made, standard meals of protein, fat or carbohydrate were given, and the increment in metabolism measured at two hour intervals for eight hours, except after carbohydrate, when the interval between readings was shortened. The Tissot apparatus with Haldane gas analysis was employed entirely in the last three years' work. Part of the earlier work was done with the Benedict portable machine.[1] In all work done with the Tissot apparatus, urinary nitrogen was determined for each period, so that the nonprotein respiratory quotient could be calculated. With the data thus accumulated we were able to study (1) basal metabolism of persons of widely varying build; (2) the specific dynamic action of food, and (3) the sources of energy after food.

The basal metabolism studies have been charted to show the variation from estimated normal of each individual, and the charts show that, despite the extremes of weight, most of the cases lie within the ± 10 per cent. usually accepted as normal; two readings are below 15 per cent. and three above 15 per cent. Of the two subjects showing subnormal readings, one had clinical signs of myxedema, and the obesity of one followed double oophorectomy. Of the three subjects above 15 per cent., one was receiving thyroid extract; one had recurrent attacks of acute polyarthritis, and one had a huge thyroid, tachycardia and nervousness.

* From the Otto Baer Fund for Clinical Research and the Gusta Morris Rothschild Fund of the Michael Reese Hospital and the Nelson Morris Institute for Medical Research.

1. Part of this work was performed in the laboratory of Professor Katherine Blunt, at the University of Chicago.

The specific dynamic action of protein was found strikingly diminished in the obese. This can easily be seen by charting the averages of all readings, yet the individual experiments exhibited great consistency in the failure of the obese to react to protein in the way normal or thin persons do. The experiments with fat meals did not reveal any difference in behavior between the three groups (obese, normal and thin). After carbohydrate, the results were inconclusive; the average curve was lower in the obese, but in individual cases the results were not consistent. Whereas after protein one can almost predict the curve of metabolism, after carbohydrate the obese persons follow no rule.

We have attempted to analyze our studies on the source of energy after the meals, but definite conclusions are withheld for the present. Studying the results after a protein meal, we fail to note any difference in the calories derived from protein by the three groups. The fat metabolism shows much more marked variations in the obese. We have arbitrarily grouped the results; the reaction curve of one group differs markedly from the curve of each of the other groups, and no such wide variation is seen in the normal cases. The carbohydrate metabolism seems to act in an inverse ratio to fat; when the calories derived from fat are high, the carbohydrate calories are low.

SUMMARY

We have shown that (1) obesity in certain persons may occur on food intakes much below their calculated caloric requirements; (2) the basal metabolism in obesity does not differ from the normal; (3) the specific dynamic action of protein is decidedly less marked in the obese than in the normal, and (4) there probably exists an anomaly of fat metabolism in the obese, the exact nature of which has not been ascertained.

The significance of these observations in solving the problem of obesity cannot be estimated until studies on the cost of work are completed and the accumulated data carefully analyzed.

TUBERCULOUS PERITONITIS AND DISSEMINATED CARCINOMA OF THE PERITONEUM

SOME POINTS IN THE DIFFERENTIAL DIAGNOSIS *

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It is almost universally conceded that tuberculous peritonitis is frequently associated with the development of a palpable mass in the abdomen. This peculiarity, together with the great diversity of the other signs and symptoms of peritoneal tuberculosis, may occasion considerable difficulty in differentiating tuberculosis from carcinoma of the peritoneum, as is apparent from the report of several cases here presented.

REPORT OF CASES

CASE 1.—*History.*—Mrs. H. B., aged 34, a married woman, whose mother died of pulmonary tuberculosis, had pertussis, measles and enlarged cervical glands as a child. At 16 years of age she had been subjected to an Alexander operation, and at 21 years to an appendectomy. She was married when 24 years old, and had two children, the first, three and one-half, and the second, five years after her marriage. Since the birth of her second child she had been unwell. Her condition had been diagnosed as neurasthenia and later as hyperthyroidism. She had lost weight and strength, had little appetite, and complained of indefinite burning pains in the abdomen, localized over the stomach, which were relieved by eating.

On her admission to Jefferson Hospital, March 11, 1922, roentgen-ray examination revealed a filling defect of the cardiac and median portions of the stomach, indicating an organic lesion of the upper three-fourths of the stomach. The roentgenologist suggested that the condition was a new growth, but suspicion was directed to tuberculosis of the stomach and peritoneum. The patient was discharged unimproved, April 9, with instructions to return later for operation. When readmitted to the hospital, April 22, after attacks of abdominal pain and vomiting, she had ascites, about 2,500 c.c. of fluid being removed by paracentesis. This fluid contained albumin, a few distintegrated mononuclear cells, and large gram-negative bacilli (probably *Bacillus subtilis*), but no pus or tumor cells. Roentgen-ray examination demonstrated that the abdominal mass had increased greatly in size. A diagnosis of gastric carcinoma having been arrived at, laparotomy was performed, May 4, disclosing what appeared to be an inoperable malignant tumor of the stomach. A section of omentum was removed for examination. The firm, yellowish-gray, shapeless mass of tissue, measuring 2 by 1 by 0.5 cm., was cut only with considerable difficulty. Histologically, after formaldehyd-alcohol fixation, the sections showed extensive fibrosis, mononuclear leukocyte infiltration, and small areas of fatty tissue. There were also a number of circumscribed foci of mononuclear leukocytes, some with necrotic centers, and a few giant cells. There being no evidence of carcinoma, the process was considered as of chronic inflammatory nature, probably tuberculous, and a diagnosis of chronic tuberculous peritonitis was made. However, tubercle bacilli were not found in sections of the tissue.

The patient continued to lose ground after the operation, and had considerable pain, with nausea and retention vomiting. Because of the clinical suspicion of tuberculous peritonitis, she was removed from the hospital for a course of heliotherapy by the Rollier technic, which was continued for three weeks with marked improvement in the patient's condition generally. The ascites, which had reappeared despite repeated tappings and injection of oxygen into the peritoneal cavity, practically disappeared, so that large fixed tumors became palpable and visible over the center of the abdomen. Animal inoculations with the ascitic fluid and urine of the patient yielded negative results for tubercle bacilli. After some time, fluid again accumulated in the abdomen, and the patient failed gradually and died in July, 1922.

Necropsy.—The necropsy, which was performed by Dr. Baldwin Lucke, was limited to the abdominal organs. An accumulation (about 2,000 c.c.) of clear, straw-colored fluid was found in the peritoneal cavity. The small intestines were agglutinated into a round mass by a partially organized fibrinous exudate. A similar substance covered the surface of the various abdominal viscera. The small stomach, about 12 cm. in its greatest diameter, had very tough walls, from 1 to 3 cm. in thickness. The gastric walls everywhere had a fibrotic appearance, with nests and irregular strands of epithelial elements and small round cells. The subperitoneal layer was considerably thickened, and contained rows of epithelial cells, many of which had undergone mucoid degeneration. The mucosa was broken over considerable areas and apparently intact elsewhere. Microscopically, its glandular elements were arranged in fairly normal order, but large numbers of mononuclear elements resembling lymphocytes were discernible between the glands. In the omentum, which was considerably thickened, the fat was almost entirely replaced by bands and whorls of connective tissue, containing scattered rows of epithelial cells, many of which were the seat of mucoid degeneration. The findings in the subserous surfaces of the intestines were similar to those in the stomach.

There was no gross or microscopic evidence of tuberculosis. The anatomic diagnosis was diffuse scirrhous carcinoma of the stomach (leather-bottle stomach) with dissemination throughout the peritoneum.

CASE 2.—*History.*—A. F., a man, aged 35, who had been a heavy beer drinker for nine years and whose sputum contained tubercle bacilli, had been subjected to laparotomy for an

* From the medical service and the pathologic laboratories of Philadelphia General Hospital.

abdominal complaint, in December, 1922, at which time a diagnosis of tuberculous peritonitis was made. He was admitted to Philadelphia General Hospital, to the service of Dr. Joseph Sailer, Jan. 26, 1924, complaining of sharp epigastric pain, radiating to the left renal region. The pain occurred after meals, appearing within two minutes after light food, and from one-half to one hour after solid food was ingested. The man's appetite had been poor for several months and he had been subject to gaseous eructations in the morning. His weight, which had averaged 139 pounds (63 kg.) during normal health, had been 128 pounds (57 kg.) a month before, and 144 pounds (65 kg.) two weeks before the date of examination. This increase had been due to enlargement of the abdomen. The man had been coughing slightly for a month, had vomited repeatedly for two weeks, and had epistaxis for ten days. The abdomen was greatly distended, and the spleen, liver and epitrochlear glands were enlarged. Palpation of the abdomen for fluctuation revealed a definite fluid wave. Four gallons of yellowish fluid was aspirated from the abdomen. The routine examination of the blood disclosed evidences of secondary anemia. The Wassermann reaction was negative. The urine contained a light cloud of albumin and a few leukocytes. Roentgen-ray examination revealed obstruction at the cardiac end of the stomach. The patient died, March 3.

Necropsy.—The body was wasted. The abdomen was protuberant and contained 6,400 c.c. of clear, yellow fluid. From the epigastric scar that remained after anterior gastroenterostomy, dense adhesions passed to the liver and to loops of small intestine, to the transverse colon and the stomach. Bands of dense adhesions were found throughout the peritoneal cavity. The mesentery was greatly thickened, and felt granular to the touch. It was studded with large nodes, up to 2 cm. in diameter. The omentum likewise contained numerous nodules, which, from gross and microscopic findings, were considered carcinomatous. The walls of the stomach were greatly thickened, being about 10 mm. at the cardia and 20 mm. at the pylorus. Evidently this thickening involved particularly the submucous layer. The greater and lesser curvatures were the seat of many nodules, varying in diameter up to 1 cm.; some of these had the form of lymph-nodes, while others were only small, white spots. Microscopically, in fresh and frozen sections there was general infiltration of carcinomatous nodules, which were composed of round, cuboidal and columnar epithelial cells, many arranged in the form of atypical tubules with marked mucoid degeneration. There was noteworthy shortening of the small intestines, the lumen of which was considerably dilated. The peritoneal surface was dotted with flat nodules of irregular form and of translucent appearance. Here and there, especially along the mesenteric border, there were larger nodules, consisting of dense white tissue and resembling somewhat caseous tubercles. On pressure, the nodules exuded a milky fluid, but their structure was not altered. There was no definite ulceration of the mucosa of the intestine, but there were a few raised patches, white and firm, some with an injected appearance. These patches did not extend beyond the ileocecal valve, although the peritoneal changes affected also the large intestine. The peritoneum was obviously the seat of secondary carcinomatosis. Metastases were found also in the esophagus, liver, cystic duct, splenic capsule, bladder, lungs and pleura. The pleural cavities contained 2,400 and 1,900 c.c. of fluid. The anatomic diagnosis in this case was interstitial gastric carcinoma (leather-bottle stomach), with dissemination over the peritoneal surface of the intestine.

SYMPTOMS AND DIAGNOSIS

One might assume that the correct diagnosis in these cases would have been comparatively easy. Nevertheless, tuberculous peritonitis was suspected in each case, and the patients were treated for this condition. In both there was a history of progressive loss of weight and strength, gastro-intestinal disorders and abdominal pain. In Case 1, the clinical findings were seemingly so definite that several consultants concurred in the diagnosis of peritoneal tuberculosis. The patient's mother had died of pulmonary tuberculosis, and the patient was known to have had enlarged cervical glands in childhood. In Case 2, tubercle bacilli were found in the sputum. Laparotomy in each case had yielded apparent evidence of tuberculous peritonitis.

Tuberculous Peritonitis.—The age incidence of tuberculous peritonitis as well as of malignant tumors of the peritoneum varies within wide limits. Some authorities consider tuberculosis of the peritoneum a disease of early life. Morley Fletcher [1] recorded eight patients under 1 year. Of 883 tuberculous children, Biedert [2] found tuberculous peritonitis in 18.3 per cent. at necropsy. In many of these there were scattered tubercles which had produced no symptoms during life. On the other hand, it is quite generally admitted that tuberculous peritonitis occurs most frequently between 20 and 40 years, in which group both our patients are included. Of 357 cases reviewed by Osler,[3] only twenty-seven occurred before 10 years of age, whereas 158 occurred between 20 and 40 years. The disease may be observed in advanced life; one of Osler's patients was 82 years old. On the other hand, the majority of cases of carcinoma of the stomach and of the peritoneum occur between 40 and 70 years. Of Osler's 150 patients, 127 were over 40 years, whereas only twenty-three were under that age.

Primary peritoneal tuberculosis is rarely observed. It may occur in children when the bacillus penetrates the intestine without producing intestinal changes. This type of infection is commonly the cause of subacute or chronic forms of the disease, with irregular nodular masses, exudation and adhesions, producing a characteristic matting of the abdominal viscera and the peritoneum into large masses. Such masses are often mistaken for tumors. The omentum may be rolled up into a firm, long mass lying across the upper abdomen. This finding is an infrequent source of diagnostic error, but unfortunately it occurs quite commonly also in carcinoma of the peritoneum. The exudate may become sacculated or encysted, either in the median aspect of the abdomen, or on either side, or a tumor may be simulated by marked thickening or retraction of the small intestine. In secondary scirrhous carcinoma also, the small intestine may be contracted into a hard mass no larger than a man's fist. In chronic tuberculosis of the peritoneum, large, fibrotic tubercles growing from the peritoneum may have every characteristic of a frank neoplasm. The onset of generalized peritoneal tuberculosis is usually very gradual. There may be a history of alcoholic excess or of other factors that predispose to cirrhosis of the liver and to tuberculous peritonitis. In patients with ascites, swelling and tenderness of the abdomen may be the first suggestive signs. These are usually due to tympanites, which, however, gradually gives place to effusion of fluid, though this is rarely large. The ascitic fluid may contain no tubercle bacilli, since these usually adhere firmly to the peritoneum. Occasionally the fluid is hemorrhagic. Gastro-intestinal disturbances, with anorexia, loss of weight and strength, and secondary anemia, become more and more pronounced. Our first patient had been treated for hyperthyroidism because of her physical decline. As ascites becomes more marked there may be edema, especially of the feet, from pressure on the inferior vena cava. Should the ascites become encysted, it may be overlooked, or its presence may give rise to a mistaken diagnosis of tumor. Ordinarily the temperature is subnormal in chronic tuberculous peritonitis. In caseous

1. Fletcher, Morley, in Garrod, A. E.; Batten, F. E., and Thursfield, Hugh: Diseases of Children, New York, Longmans Green & Co., 1913, p. 242.
2. Biedert: Jahrb. f. Kinderh. **21**: 158, 1884.
3. Osler: Practice of Medicine, New York, Ed. 9, 1920, pp. 180, 489.

or ulcerative forms of peritoneal tuberculosis, especially as a sequel to other types, there may be irregular fever, due to caseation of the tuberculous nodules, with discharge of pus. In obliterative forms of tuberculous peritonitis, the symptoms and clinical signs may be even more vague. There is often evidence of chronic intestinal obstruction, constipation, flatulence and indefinite, more or less constant, abdominal pains.

The abdomen is rounded or globular. As the pressure from the fluid increases, the subcutaneous veins become prominent. The skin is tense and glistening, dry and inelastic. There may be pigmentation, simulating Addison's disease. The respirations are rapid and shallow if there is much pressure on the diaphragm. The patient's face is emaciated and drawn, with an anxious expression. There may be simultaneous pleurisy with effusion, an important diagnostic point. Palpation may reveal the thickened omentum forming a long roll across the upper abdomen, tumor-like masses due to enlarged glands, and contracted and adherent coils of intestine. These masses are usually tender and are not freely movable.

Cancer of the Peritoneum.—Very few of the foregoing symptoms and signs are so characteristic as to preclude a diagnosis of carcinoma of the peritoneum. The latter is usually secondary to cancer elsewhere in the body, especially to disease of the stomach, liver and pelvic organs. Warthin [4] maintains that most reported cases of primary carcinoma of the peritoneum have not been clearly differentiated from so-called endothelioma. Extension takes place directly from adjacent viscera or by way of the lymph or blood from more distant organs. As in tuberculosis, the retroperitoneal and mesenteric glands are usually involved. The omentum is frequently contracted into a thick, indurated mass with the same gross characteristics as in tuberculosis. There may be massive, irregular tumors in the abdomen, or scattered collections of soft colloid material or irregularly distributed nodules. In the scirrhous form of carcinoma, the small intestine may be contracted into a small, hard mass, or the various coils may be matted together by sheets of connective tissue. As in our cases, without evidence of a primary lesion the picture is often that of chronic ascites with progressive loss of weight and strength. The fluid accumulation is usually larger (4 gallons in one of our patients) than with tuberculous peritonitis. It may be clear, opalescent or amber colored, but is more often hemorrhagic. A preponderance of endothelial cells or large mononuclear cells in groups is presumably suggestive of carcinoma, as distinguished from a preponderance of lymphocytes in tuberculosis, especially in patients over 40 years of age. On the other hand, with colloid carcinoma the abdomen may be filled with a semisolid, gelatinous mass which is not fluctuating, but firm. The appearance of the abdomen, if there is ascites, is not unlike that in tuberculous peritonitis with effusion. All the symptoms related to displacement of the diaphragm by the fluid collection may be found in cancer as well as tuberculosis. There may even be secondary carcinoma of the pleura with effusion (as in Case 2). Fever is more common in carcinomatous than in chronic tuberculous peritonitis.

DIFFERENTIAL DIAGNOSIS

Since gastro-intestinal disturbances, emaciation, loss of strength, fever, abdominal discomfort and pain, ascites and presence of tumors are common features of tuberculous peritonitis as well as of peritoneal carcinoma, a painstaking inquiry into the history and a careful physical examination will usually be required to determine the primary cause. Young subjects are more apt to have tuberculosis than cancer.

The tuberculin test does not furnish sufficiently reliable evidence for a definite diagnosis. A history of a previous attack of ascites, with sweats and tachycardia, favors tuberculosis. Fever and bradycardia are found more commonly in carcinoma of the peritoneum. The carcinomatous masses are usually of wooden consistency, though in colloid cancer the abdomen may be filled with a semisolid substance. Since peritoneal cancer is more commonly a complication of gastric disease, a gastro-intestinal examination may present suggestive evidence. There may be motor insufficiency of the stomach, and gastric analysis may demonstrate persistent diminution of hydrochrolic acid, and the presence of lactic acid and blood. As described by Ziegler and others, however, hyperacidity may be found in early cancer. With the appearance of lactic acid and persistent diminution of hydrochloric acid, the ferments also disappear in 89 per cent. of cases of gastric cancer. The finding of the Boas-Oppler bacillus with clots of blood, in the absence of hydrochloric acid, is almost pathognomonic of cancer. Microscopically, blood cells, blood pigment and pus cells in the stomach contents constitute significant evidence of malignant disease. Later, there may be found shreds of mucosa, with glandular atrophy, or a piece of tumor tissue. In many cases, a definite diagnosis will be impossible without histologic examination of a section of tissue removed in the course of exploratory laparotomy. But even such findings may be misleading, as in our cases. An excellent therapeutic test of the diagnosis of tuberculous peritonitis is offered by heliotherapy according to Rollier's method, which, as Lo Grasso [5] has recently brought out, produces definite and permanent improvement in the majority of cases of tuberculous peritonitis.

SUMMARY

1. In two cases of diffuse carcinoma of the peritoneum which came to necropsy, tuberculous peritonitis was the clinical diagnosis, and this was confirmed by a pathologic report on a section of omentum, removed in one case during laparotomy.

2. The determination of the existence of a primary focus of tuberculosis should not preclude the possibility of carcinoma existing in the peritoneum.

3. Since the symptoms and physical findings may be strikingly similar in tuberculous peritonitis and carcinoma of the peritoneum, a painstaking consideration of the differential features is essential. Heliotherapy is an excellent therapeutic test of the diagnosis of tuberculous peritonitis, since it produces definite improvement in the majority of cases.

4. The unusual character of the metastasis in these cases is noteworthy.

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4. Warthin: Reference Handbook of the Medical Sciences, New York **7**: 124, 1917.

5. Lo Grasso: New York State J. Med. **22**: 281 (June) 1922.

Freshmen's Defects.—Among 1,903 first year students examined at the Ohio State University, Columbus, 94.2 of the men were found physically deficient in some respect. Measles was far the most usual childhood disease reported by students. More than four of five having had measles, pneumonia was next, then scarlet fever, diphtheria, typhoid, smallpox and rheumatism.

CHOLECYSTOSTOMY VERSUS CHOLECYSTECTOMY *

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Interest in surgery of the gallbladder and bile passages received its greatest stimulus with the introduction of cholecystectomy by Langenbuch in 1882. Observations at the operating table and laboratory studies of the removed organ, since that time, have borne fruit in the knowledge of the diseases of the gallbladder which is at our command today. This knowledge is quite wide, but there are many questions and many problems that await solution, one of which in its practical aspects is before us for discussion in this paper.

After the first rush of enthusiasm which greets almost every innovation, colder judgment, with more facts at its command, begins to question the rationale of the innovation. In surgery, we hear the swaying of the pendulum in the cry that we are removing too many appendixes or that we are performing too many gastroenterostomies. Gallbladder surgery is no exception to the rule, and today the question of cholecystectomy versus cholecystostomy is again or, perhaps, is still occupying the minds of the clinician, the pathologist and the surgeon alike.

In considering the surgical aspects of this subject, the immediate questions that present themselves for answer are: (1) the indications for surgery in cholecystic disease; (2) the type of operation, and (3) the end-results. As in any other subject dealing with disease, the prime considerations are the questions of the pathogenesis and the course of cholecystitis, especially calculous cholecystitis. There is little difference of opinion today that it is not the gallstones per se, but the inflammatory processes induced by the calculi that determine the gravity of gallstone disease; the severe pain is chiefly an expression of the inflammatory process produced by the stones. This merely shows, in other words, that acute and recurrent attacks of gallstone colic are practically always due to acute and recurrent cholecystitis, cholangeitis, pancreatic lymphadenitis, subacute pancreatitis, or all of them. The surgeon, therefore, encounters in his work the effects of the inflammatory process, and his efforts are directed toward removing their results and preventing their recurrence or continuance. Grossly, we have gallbladders that can be arranged in series so as to show every stage and type of infectious inflammation: enlargement, acute and chronic exudates, infiltrates, and fibrinous and fibrous adhesions to neighboring organs. With each repeated attack of cholecystitis, there is another change added to the already altered structure of the gallbladder, now in the form of thickening of its walls, now in the form of ulcers, now in the form of cicatricial contraction, and so on. We will return to the subject of the pathologic anatomy later.

CLASSIFICATION

Clinically, we may classify gallbladder cases in a number of ways, but a very useful classification is that which divides them into those that have had a single attack which never recurs or in which recurrence does not take place for a number of years, and cases of persistent infection. Recurrence, when it does occur in the first type, is evidently the result of a new infection, and these cases may or may not subsequently fall in with the second and much larger group of persistent infection of the gallbladder, in which the attacks greatly increase in severity and frequency until, eventually, operative relief is imperatively demanded. Without further discussion, we shall maintain the position that we have held for many years; namely, that in the first mentioned group of cases it is policy not to operate in or after a first acute attack, but that as soon as a case falls into the second group, it belongs to the class in which surgery is indicated. And we must repeat and emphasize, over and over, that the earlier the surgery is undertaken when this diagnosis is established, the greater are the chances for ultimate cure and entire well-being. Both the profession and the public, responding to the propaganda of the last several decades, have begun to realize the possible remote effects of acute appendicitis, and are ready and anxious for operation; but they do not as yet realize the strong resemblances between acute appendicitis and acute cholecystitis.

EFFECTS

The possible effects are very much the same as far as suppuration, gangrene and perforation are concerned. The remote effects are just as grave, if not more so, when diseases of the gallbladder are allowed to progress with acute exacerbations, or even to prolonged chronicity without acute recurrences. The greatest menace, of course, is the formation of gallstones or the immediate effects of calculi already present, which sooner or later bring into involvement the common and the hepatic ducts and the pancreas, to say nothing of the liver, and general sepsis of the entire body. It is in the cases in which operation is performed as a last resort and "the morphin needle has been the frequent victor in the battle of the gallbladder for relief, and the patients have reached a state of physical and nervous collapse" that the end-results discredit surgery. Patient and physician alike are apt to think that each attack is the last, and so it may be—the last one before perforation, which is more frequent than is generally supposed. Protective barriers in the shape of adhesions often successfully prevent catastrophes, but pericholecystic adhesions are one of the serious menaces of repeated attacks of cholecystitis. The patient with many pericholecystic adhesions can seldom be made entirely free from symptoms.

One last word concerning calculi: It must be borne in mind that, in nearly all instances, they originate in the gallbladder, and the stones or particles of stones found in the ducts are particles or actual stones that have escaped from the gallbladder. Choledocholithiasis is a very unpleasant chapter in gallbladder surgery, and in many instances it is a sad commentary on medical practice. Prophylaxis of the stones in the common duct is possible by the early removal of the stones from the gallbladder.

COURCES OF PROCEDURE

And now the question arises: Should the gallbladder be removed or should it be drained? To express an opinion on this subject, it is necessary to consider it from many angles, beginning naturally with the function of the gallbladder. We may say that this is still an unsettled question. We have abundant evidence to tell us that its contractile power is quite low, that it probably never exerts a greater pressure on the bile

* Read before the Section on Surgery, General and Abdominal, at the Seventy-Fifth Annual Session of the American Medical Association, Chicago, June, 1924.

than the pressure which the liver in secretion can produce. This means that if the squirting out of bile should be important, it is never done; that is, there is no mechanism for squirting out the bile as we should imagine there is in an organ with muscular activity, such as the urinary bladder. It concentrates the bile, and from recent studies we have quantitative data on the rate at which this can be done. The liver probably secretes more or less continuously, although at a varying rate. It is known that the bile does not flow into the intestine continuously, but only when digestive demands are made on it. The gallbladder then receives the bile during the interim. It cannot store the quantity that the liver secretes, so the bile is concentrated and made to occupy less space.

There are, however, several questions that have not been answered. We know that the gallbladder adds mucus to the bile. Does it add anything else? We know that the gallbladder concentrates the bile by removing at least what amounts to a normal saline solution. Does it remove anything else? The answers to these questions are not as yet forthcoming, but the crux of the situation in regard to the physiology lies in these thoughts. We do not remove a normal gallbladder. This presupposes that we can recognize when a gallbladder is diseased, and this will be discussed presently. When we remove a diseased gallbladder, the crucial question is how much of a change must be present in the organ to prevent it from functioning normally. We cannot answer this question quantitatively, except in the extremes. When it is normal in appearance, we assume in our practical work that the gallbladder is functioning normally; when its walls are one-half inch thick and saturated with suppurative exudate, when its contents are pus, stones and sand, we assume that the gallbladder did not function.

The borderline cases, between normal and very slight disease, are the ones in which we are chiefly interested. Suppose we remove a normal organ. Do any bad results follow? Dilatation of the ducts, incontinence of bile, and other such sequelae have been found; but it is extremely doubtful whether these are of any great importance in the general metabolism of the body. We have as a basis for this statement not only experimental but also clinical results in two directions: in the one, in which gallbladders, almost normal, have been removed, and this has possibly happened in a number of cases, we have heard of no serious results; in the other, many hundreds of patients have had their gallbladders so destroyed by disease that all the specific structure has been replaced. They have been as good as without a gallbladder for a number of years. They have had symptoms which, we can say with great assurance, are due not to the loss of gallbladder function, but to the infective processes; because when the functionless gallbladder has been removed by cholecystectomy the patients have been to all intents and purposes well. In brief, since the proof of the pudding is and always will be the eating, we know that clinical experience has proved beyond a doubt that mankind, particularly womankind, can get along very well without this organ.

PATHOLOGY

We must not consider the pathologic aspects of the subject. First and foremost is the question of the recognition of early and irrecoverable disease of the gallbladder. We have said that it is not our policy to operate in or after the first acute attack of cholecystitis. When we operate in acute cholecystitis, it is, therefore, on the patient who has had the history of previous acute attacks or of continuous trouble in the upper right abdominal quadrant. We say the latter advisedly, for there is no man living who can always distinguish between cholecystic disease, gastric or duodenal disease, disease in an appendix in a high position, and so on. Given a patient, therefore, who presents symptoms in the upper right abdominal quadrant, at operation it is necessary, if the pathologic condition is not extensive—and it is just this type of case which we as surgeons are always hoping for, are always praying for and are always asking our medical confrères to send us—to find the lesion causing the patient's sufferings.

We need not dwell on the signs of gross acute inflammation in any organ. These we all can recognize; but in chronic cholecystitis, the organ may be large or it may be small. Its walls may be thick or they may be thin; there may be adhesions or there may be none; the factors that produce these different anatomic pictures are familiar enough. They include number, type, virulence of the bacteria, age of the process and position of the granulation tissue deposited. In the organs that are only mildly diseased, the walls will be slightly less translucent; they will not have the same tonicity; instead of a steely blue color, there will be an admixture of gray. When the gallbladder is emptied, the walls remain partly or wholly flaccid. The aspirating needle withdraws very black bile, perhaps finely granular. There is no other demonstrable lesion in the stomach or duodenum. We make the diagnosis of chronic cholecystitis.

Shall we remove the organ? Will it recover under drainage? Has the organ been performing its function? If not, will its function be regained? These questions as yet can be answered only by opinions, with only one exceptional fact standing out clearly, and that is that bacteriologic examinations of this organ in our own clinic, and in a number of other clinics as well, have shown that they are often infected not in their mucosa alone but also in their walls, and yet may show but slight gross changes. We prefer to remove this organ, and we are led to do this through a number of circumstances.

ROUTES OF INFECTION

As to the route of infection, the possibilities are through the blood stream, by way of the cystic artery; up from the duodenum by the lumen of the common duct and cystic duct; from the intestine through the portal vein, through the liver, and down by way of the hepatic ducts; from the intestine through the portal vein, through the liver and into the gallbladder through the lymphatics of the portal spaces; and, finally, ascending from the duodenum through the lymphatics in the walls of the common duct. It is not a question of which is the mode of infection, but which is the mode of infection in any particular case, for, according to our belief, infection may take place by any, several or all of these routes.

The pivot about which the discussion revolves is that the gallbladder, in any event, no matter by what route infected, can be and is the distributing point of infection in all directions; in other words, a gallbladder once infected may continually reinfect itself and keep spreading the infection to neighboring organs. To illustrate: Bacteria are present in the bile, and stasis from some cause or another allows proliferation. The mucosa of the gallbladder is invaded; bacteria enter the lymphatics; they spread into the liver by which they may be excreted, and they again reenter the gallbladder, and so

on in a vicious circle. The same argument may be used for any of the other modes of transmission. When we remove the gallbladder, therefore, we break into the center of the vicious circle, and thus it is demolished. At this point in our discussion, the question is not as yet answered: Does the gallbladder recover after drainage? But once more the proof of the pudding will be forthcoming, presently, as to comparative clinical results.

RELATIVE RISKS

In the larger clinics and among the more experienced surgeons, the relative risks of cholecystectomy and cholecystostomy no longer play a part in the discussion. In fact, if cholecystostomy today is followed by a higher immediate mortality (in the hands of the expert surgeon), it is because this operation is nearly always reserved for the more desperate cases. In severe acute appendicitis with extensive pathologic changes and abscess formation, appendectomy must often be deferred for a secondary operation, and it is just so in severe cholecystitis. Generally speaking, however, the day is past when it is considered safer to omit than to commit as far as the removal of the gallbladder is concerned. With the development of the technic of cholecystectomy and its perfection, and with the clinical experience of the possible sequelae of the conservative drainage operation, the radical procedure is now usually given the preference, except perhaps for the occasional operator. In the hands of the average surgeon and in the average case, drainage is of course technically easier than removal, but the end-results are certainly not so satisfactory, and we have reserved the answer to the query propounded above to this point.

It is the experience of the Lankenau clinic that of the patients with disease of the gallbladder and bile passages that come for reoperation, 81 per cent. still have their gallbladders. Therefore, if we arrange the causes of recurrence according to the type of operation, cholecystostomy would most certainly be in the class of improper procedures, while recurrence of symptoms after cholecystectomy would probably be due to imperfect operation in a certain percentage of cases; that is, to failure to remove a stone or stones at the primary operation, operative traumatism and the like. The most important possible sequelae of the conservative operation are stones in the common duct and pancreatitis, by extension from the interstitial cholecystitis.

Our views on the question of pancreatitis are too well known to need reemphasis at this time. We still believe that interstitial pancreatitis results very frequently from lymphatic borne infection from the gallbladder, and we have said that removal of the gallbladder breaks the vicious circle. Indeed, so persistent are the effects of prolonged chronic cholecystitis that pancreatic disease is often already incipient, if not established, at the primary operation, and we need not point out that pancreatitis is also a more or less potent cause of the recurrence of symptoms after cholecystectomy. It is in these cases that the argument in favor of cholecystostomy is advanced, as the retained gallbladder is found useful for making a cholecystoduodenal anastomosis; but the fact that of the recurrences after operation only about 8 per cent. are cholecystectomized patients, and that of these 12 per cent. have symptoms of chronic pancreatitis, appears to us an additional and much better argument in favor of the removal of the organ, since with it the possibility of pancreatitis is removed in 88 per cent. of the cases.

CONCLUSION

From the foregoing, therefore, it appears that cholecystectomy is the operation of choice. It is as safe as cholecystostomy; it removes the cause of the vicious circle; the patient does not miss an organ which has probably been functionless or in which function has been much impaired for some time, and the chances of complete recovery or cure are greater, recurrences being less frequent and usually less serious than after cholecystostomy.

1634 Walnut Street.

ABSTRACT OF DISCUSSION

DR. STANLEY REIMANN, Philadelphia: As Dr. Deaver says, it is known that the gallbladder concentrates bile by removing certain substances from the body. To the clinician, the question of importance is, What does the gallbladder take out? Dr. Mann of Rochester discovered accidentally that by injecting surgical solution of chlorinated soda intravenously it was possible to produce a cholecystitis. Dr. Sweet and I have repeated these experiments. It is quite interesting to anesthetize a dog, expose the gallbladder, and inject a certain amount of this solution intravenously. After a longer or shorter period, usually a shorter, the walls of the gallbladder become discolored, and soon the entire organ takes on a gangrenous hue. In a few days, the organ is a gengrenous mass. This means that the gallbladder has a specific function. It seems to take up this solution, or, if we want to look at it in another way, the solution seems to have an elective affinity for the gallbladder. This is an interesting physiologic discovery. Some years ago, Dr. Deaver used to say, when a patient came to him for gallbladder disease, that he had been to Carlsbad and had the stones removed on two or three occasions, and when he removed the gallbladder he would drop the stones into a dish to hear them click. It has been impossible for some time for Americans to go to Carlsbad. But something else has interested Dr. Deaver, and that is the medical drainage of the gallbladder. Patients are now coming to him because of the so-called medical drainage of the gallbladder. Coupled with the function of the gallbladder is the larger one of liver function. When there is an extensive cholecystitis, especially of long duration, the liver is bound to be affected. Fortunately for us and for the patient, there is a large element of safety in the liver. Unfortunately, in some cases the liver plays a large part in the postoperative course and in the restoration to health of the patient. If we could get a physiologic method by which we could test the function of the liver, we would find many expressions of liver function. The work of Ludwig and Heidenhauer stands out as the most important on this subject. The liver is more complicated in its function than the kidney because the liver not only excretes bile but also plays a very important part in the general metabolism. We can collect urine easily, but we cannot easily collect the bile. These tests for liver function, which are important for good treatment of gallbladder disease, are much to be desired. It is on these that the question of cholecystotomy versus cholecystectomy will hinge.

DR. J. EARL ELSE, Portland, Ore.: Some of us who are inclined to study the pathologic side of things like to know why the gallbladder is subject to these conditions. In 1912 and 1913, while in Vienna, I studied 1,000 gallbladders in adults and 100 in the new-born. I found certain conditions that could not be cured by drainage. One was the presence of Luschka's ducts. Luschka, in 1870, reported the presence of so-called ducts in the diseased gallbladder which were never present in the normal gallbladder, and in these 1,000 cases we noted that in the gallbladders that had been subject to inflammation over a long period these ducts or glands had developed. Sometimes these were true glands which extended into the mucosa and down into the muscularis and even under the serosa. In one case, in which there had been an obstruction to the gallbladder, these ducts had developed until they were as large as my thumb, retaining fluid and secondary infection. In these ducts we found bile pigments,

showing that the bile had extended up into the ducts. In many we found evidences of infection. Another thing we found was the so-called elbow deformity, in which, as the gallbladder develops, the upper end becomes turned over and constricted. Within the last month I saw a patient, who had been treated two or three years by biliary drainage before the operation, who had one of these elbow deformities which was infected. The infected material could not get out, and that is why there were no results from drainage, so called. Another thing that tends to keep up infection of the gallbladder is the abnormality occasionally found in Heister's valves. This is a spiral-like structure extending up into the cystic duct. In one instance I found a Heister's valve larger than the cystic duct, so that there was a definite bulging in the cystic duct wall from this enlarged valve. When we find these things we realize the truth of what Dr. Deaver has been telling us for many years—that a chronically inflamed gallbladder should always be removed.

DR. FLORUS F. LAWRENCE, Columbus, Ohio: The thought occurs to me that we are placing too much dependence on the mechanical part of our treatment. That is one of the reasons why there is so much difference of opinion as to the value of cholecystectomy and cholecystotomy. It is also strange that five to one or more bile tract infections occur in women. The majority of bile tract infections, if not all, follow as a result of a focus or foci in the lower part of the abdomen, from typhoid fever, appendicitis, pelvic infections, pararectal infections, etc. In all probability these infections follow the lymphatics, along with the portal system, up to and through the liver; hence primary infection occurs not in the gallbladder but in the minute ducts and in the tributary structures of the liver substance itself. To support that is the well known fact that we cannot make a culture of pathogenic bacteria from normal bile. Then, another thing—if we cannot drain through the common duct an infection from out of the smaller ducts and the substance of the liver itself with the gallbladder present, how can we expect to drain it through the common duct after we remove the gallbladder? Not an infrequent finding is a septic serosa, unquestionably the result of bile tract infection. How can you expect to cure the condition or even ameliorate it unless you drain the substance of the liver in its minutest ducts? The trouble is that much of our drainage is not drainage. We cannot drain with a gauze dam. It is impossible. The only thing it brings out is serum, and that does no harm. We want to get out the blood clot that makes the culture medium, and we cannot do it with gauze. We must do it by means of a tube that will not close off by muscular contraction. In my judgment, it requires more skill to perform a cholecystotomy and provide through drainage than to do a cholecystecotmy and close the wound. I do not wonder that men get tired of drainage when they have to depend on assistants who are more or less indifferent. I sometimes wish that there were not such a thing as drainage, but we cannot get away from it. Certain ducts and certain substances of the liver are left after a cholecystotomy. There may be a rupture or a perforation of a gangrenous, fibrotic gallbladder in which the cystic duct is already obliterated or has ceased to function.

Present-Day Knowledge of Children.—Man's greatest interest is in children. However, something radical must be done because as a group we are losing ground. The antisocial element is increasing and the burden of the insane and feebleminded is becoming heavier. The explanation is that we have mistaken symptoms for causes. The cause of crime, insanity, and delinquency is not anything so simple as the movies, or alcohol. The cause is to be sought and found in man's inherited tendencies, which do not fit his present world, and we have not tried efficiently to modify them. We know better than ever before the nature of the child, the wide range of capacities in children and the necessity of adapting the training to the nature and ability of the individual child. . . . We already know enough if put into practice to transform civilization within a generation or two.—The Child, His Nature and His Needs, The Children's Foundation, 1924.

Clinical Notes, Suggestions, and New Instruments

COMBINATION STETHOSCOPE

MYER N. MOSS, M.D., ST. PAUL
Assistant in Obstetrics and Gynecology, University of Minnesota Medical School

The DeLee-Hillis obstetric stethoscope has its value in that it enables the operator, after he is scrubbed and the patient is prepared, to observe closely and follow the fetal heart during the course of the delivery. In addition to this most important

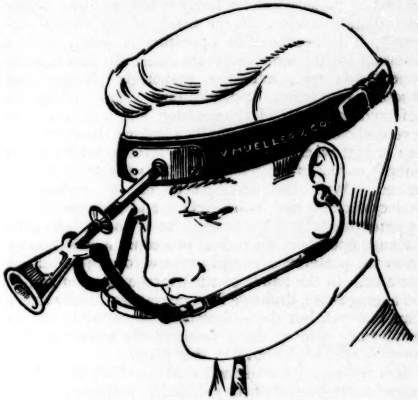

Fig. 1.—Combination stethoscope as worn.

feature, it is found that when it is used the heart tones are much louder and more distinct, so that they may be heard much earlier in gestation than with the ordinary stethoscope, and that if they are not heard in the last trimester, the fact gives almost a pathognomic sign of fetal death. This, in part, is due to the fact that the rod leading from the mouthpiece

Fig. 2.—Head piece, which may be folded.

Fig. 3.—Stethoscope detached.

rests on the forehead of the operator, so that the impact of the fetal heart is also transmitted and is felt as well as heard.

The combination stethoscope (Fig. 1) is similar to the original head stethoscope, as devised by DeLee-Hillis, except for the projecting margin at the point of junction between the head piece and the stethoscope proper. The head piece (Fig. 2) is made of leather and may be folded and carried in the bag

or pocket conveniently. Several head bands may be had, and one kept at each of the places where needed most. The stethoscope (Fig. 3) has a thumb-rest, and is not unlike the ordinary stethoscope, serving the same purpose just as efficiently.

The advantages are the same as those afforded by the DeLee-Hillis head stethoscope, and it serves the combined purpose of a general and an obstetric stethoscope. A single stethoscope with several head pieces will give the same uses as several head stethoscopes plus one general stethoscope, at a small cost above the price of one.

336 Lowry Building.

STOMATITIS FOLLOWING THE INJECTION OF MERCUROCHROME-220 SOLUBLE IN A TUBERCULOUS SINUS

CHESTER C. GUY, M.D., CHICAGO

Bunten[1] recently reported salivation following the intravenous use of mercurochrome-220 soluble. Because of the growing popularity of this preparation as an antiseptic and stimulant in the treatment of infected wounds, sinuses and various skin disorders, the following case report of stomatitis developing after the injection of mercurochrome into a tuberculous sinus may be of interest in emphasizing that its use is not entirely innocuous.

REPORT OF CASE

Mrs. M. C., aged 33, entered the Cook County Hospital in the service of Dr. F. C. Test, complaining of a tuberculous hip of fifteen years' duration. Discharging sinuses in the region of the greater trochanter had been present eight years, and various solutions and pastes injected into the openings had resulted in no improvement. These sinuses communicated, through the acetabulum, with an abscess cavity in the pelvis on the inner surface of the ilium. March 22, 15 c.c. of a 1 per cent. solution of mercurochrome-220 soluble was injected into the sinuses after irrigation with physiologic sodium chlorid solution. This was repeated daily, and a marked decrease in the amount of the discharge was noted. Improvement continued until April 10, when the patient began to complain of soreness in the gums, profuse salivation, loosening of the teeth, and diarrhea. These symptoms increased rapidly in severity, and the next day the injections were stopped. Two weeks later, the stomatitis and diarrhea had entirely disappeared, and they have not recurred since. The patient gave no history of a previous similar affection of the mouth. The length of time (nineteen days) before the appearance of symptoms of mercurial poisoning, and the two week period required before they had disappeared, are explainable on the slowness of the absorption of the mercury into the walls of the chronic abscess cavity.

Cook County Hospital.

1. Bunten, J. C.: Salivation Due to Intravenous Use of Mercurochrome, J. A. M. A. 82:1443 (May 3) 1924.

SUBCUTANEOUS EMPHYSEMA FOLLOWING TONSILLECTOMY

CHARLES ROSENBAUM, M.D., NEW YORK

Subcutaneous emphysema following tonsillectomy is a rare complication, whose mechanism is ill understood at present. In looking through the literature I found the cases that were reported gave no definite suggestion as to what the causes of the emphysema were.

My case was that of a woman, aged 35, who had her tonsils removed by dissection and snare. General anesthesia was used with suction spray apparatus. The patient went under the anesthesia without difficulty; there was no coughing on going under or coming out. There was little bleeding and no difficulty in removing the tonsils.

Ten minutes after the operation, a marked swelling was noticed on the eyelids, face and neck of the right side and also the neck of the left side. On feeling this swelling, I noted a distinct egg-shell crackling. After the patient had come out of the anesthesia she called my attention to the fact that she could feel the crackling in her neck. Beyond this she experienced no discomfort, her breathing never being embarrassed at any time. The swelling completely disappeared in three days. The tonsil site healed in the usual time. This case is presented both on account of its rarity and because the production of the emphysema is not understood.

107 West One Hundred and Twenty-Third Street.

A CASE OF POISONING DUE TO CAMPHOR LINIMENT

MILTON C. LANG, M.D., BALTIMORE
Physician to the Maryland Penitentiary

E. K., a man, aged 44, a prisoner at the Maryland Penitentiary, while in his cell called for a dose of castor oil. By mistake he was given an ounce of camphor liniment by an attendant, which he drank unknowingly at 9 p. m., April 3, 1924. He was not seen again until 10:45 p. m., when he was found in a convulsion of epileptiform character, which lasted six minutes. He then recovered consciousness, and complained of weakness, inability to stand up, nausea, nervousness, severe headache and pain in the eyes. His condition rapidly grew worse, and he became semidelirious. Although no definite convulsions were noted, there were frequent twitching movements of the lower extremities. The patient was restless, his skin was pale and clammy, the pulse regular but rapid; the blood pressure was 120 systolic, and 75 diastolic. The respirations were loud, rapid and shallow, but were frequently interrupted by deep gasps.

Therapy consisted of gastric lavage. The return flow smelled strongly of camphor, and small droplets of liniment floated on the surface of the water. Several ounces of magnesium sulphate were left in the stomach.

In the morning the patient was much better, complaining only of slight nausea. He remembered nothing after taking the liniment, and was surprised to find himself in the prison hospital.

His temperature was normal throughout, except at 4 p. m., April 4, when it was 99.2 F. His pulse rapidly came down to normal.

The patient was discharged from the hospital, April 6, and no further ill effects were noted.

New and Nonofficial Remedies

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION. W. A. PUCKNER, SECRETARY.

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Petrolagar (with Phenolphthalein): Liquid petrolatum 65 Cc., agar 10 Gm., phenolphthalein 0.33 Gm. (1½ grains in one fluidounce), sugar and flavoring 2 Gm., sodium benzoate 0.1 Gm., water to make 100 Cc.

Petrolagar (Alkaline): Liquid petrolatum 65 Cc., agar 10 Gm., milk of magnesia 25 Cc., sugar and flavoring 2 Gm., water to make 100 Cc.

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SATURDAY, JUNE 28, 1924

MALARIA CONTROL IN PALESTINE

It no longer requires a sustained argument to support the thesis that malaria is one of the endemic diseases that must have played an important part in the progress of certain nations and thus in the history of the world. Today it is malaria control, rather than the peculiarities of the disease itself, that excites interest in a popular way. Even the man in the street has come to know that such enterprises as the building of the Panama Canal have been rendered effectively possible as a result of the modern discoveries that relate to malaria and yellow fever. He probably will not, however, realize how comparatively recent is all the information that has served to dispel the old medical ignorance about malaria. It was in 1880 that the French army surgeon Laveran discovered the parasitic micro-organism that he proved to be the true cause of malaria fevers. Not until 1898 did Sir Ronald Ross demonstrate conclusively that the malarial parasite is absolutely dependent on certain species of mosquito for its transmission from man to man. The curative treatment of malaria through the use of quinin and other drugs of course has a longer history. The efforts to eradicate it on the basis of the newer fundamental information have been confined to the present century. So long as thousands of persons still are "annually sacrificed on the altar of the malarial parasite," the campaigns for relief from such a situation must not be abated. The problem is one for communities or governments rather than for the individual. Ross, indeed, has maintained that malaria is essentially a political disease—one that affects the welfare of whole countries; and the prevention of it should be an important branch of public administration. For the state as for the individual, Ross contends, health is the first postulate of prosperity; and prosperity should be the first object of scientific government.

Theoretically, malaria might be eradicated in two quite different ways. If the mosquito were effectively exterminated or excluded from human relations, the parasites would lack a vector and their spread would thus cease. Or, if the malarial parasites could be destroyed in every human host by the use of quinin or its substitutes, the disease would cease with the disappearance of the primary etiologic agent. Neither of these procedures is completely feasible under present-day conditions; and even if they were humanly possible, we should be promptly admonished to count the cost. Even human life has only a limited economic value, with which budgets must reckon. As the malarial parasite has two hosts, man and the mosquito, it has been found more practicable in some cases to alternate or even combine the place of attack. This means mosquito control in the one case and, in the other, wholesale persistent treatment with quinin for passive carriers as well as for active patients.

Of late, much attention has been devoted by the U. S. Public Health Service, the International Health Board and other agencies to the economic phases of malaria control. The possibility of control is abundantly demonstrated and admitted. The foremost question when larger areas are involved is whether the cost of malaria control will be less than the economic tax imposed by the existence of the disease. This is particularly important in small areas where the economic conditions offer barriers to large expenditures. In other cases, ignorance and prejudice may become inhibitory factors against the efforts toward sanitary progress. Malaria is the most prevalent and economically the most important disease in Palestine, which is at present experiencing a renaissance of civilizing influences. Working with the Hadassah Medical Unit at Jerusalem, Kligler [1] has been engaged in a study of the possibilities of malaria control with limited means where large scale operations are at present impossible. A few typical areas were selected. It was early recognized that an essential element in the control demonstration must be the attack on the parasites in man. In order to reduce the incidence of malaria, it was first of all necessary to reduce relapses of chronic malaria patients and eliminate parasite carriers. Consequently, the first step was to examine the entire population in order to detect the carriers, and the second to systematize and regulate the treatment. All carriers received 2 gm. of quinin by mouth daily for five days; and, after an interval of two days, to permit blood examinations, ⅔ gm. was given daily, for two months. Relapses were treated as new infections, and anemic patients received additional therapy with iron and arsenic.

The greatest emphasis was laid, however, on measures against mosquito larvae; and this work was facilitated by educational propaganda. Although the same methods cannot be applied alike in the places where water is overabundant as where adequate drainage has been perfected, Kligler believes that malaria control is clearly feasible with relatively small expenditures in some of the worst areas in Palestine, and that there is consequently every reason to expect that it will be likewise applicable elsewhere in that country. Drainage

1. Kligler, I. J.: Malaria Control Demonstrations in Palestine, I, Malaria Control and Its Cost, Am. J. Trop. Dis. 4: 139 (March) 1924.

and proper control of irrigation are of the foremost importance. Intermittence of irrigation has proved to be very advantageous when it can be properly effected. Constant supervision is essential, for no amount of sanitation will always entirely overcome human ignorance or negligence. The per capita cost may not exceed $2.50 for the first year, and should subsequently become much lower. It is gratifying to learn that the results achieved in the communities involved justify the continuance and extension of the demonstrations to other parts of Palestine. They may become models for other localities where discouragement has thus far beset the promoters of preventive medicine.

MILK CONSUMPTION IN THE UNITED STATES

A student of nutrition [1] has recently reminded us that the history of science warns against the dangers of dogmatism in the presence of so much that remains unknown or unapproachable. When experience and science seem to be in conflict, it is particularly well to keep an open mind. The science of nutrition is in the midst of a continual evolution of facts and development of truth. The propagandist employs striking slogans or euphonious catch phrases in order to promote his aims. Publicity promoted in this way may be highly appropriate and effective; no one, for instance, would interpose objection to the widely heralded admonition of "safety first." This does not apply without exception, however, to all the dogmatic assertions that are purveyed flamboyantly to the public. Indeed, THE JOURNAL has criticized some of the current advice [2] that is supposedly directed through nation-wide advertising in the interest of the public health or the nutritive welfare of our population.

The use of milk and dairy products is being promoted by many agencies in this country. The recommendation of "a quart a day for every child, a pint for every adult," has come to have a familiar ring; it has been urged since the days of the World War as not too high an ideal.[3] The unusual nutritive virtues of milk have become familiar not only to "experts" in nutrition but even to every school child in these days when food values are a topic of conversation in the school and home, and when the popular magazines feature calories and vitamins in every issue. It may not be amiss, however, to remind the public again and again that milk is unique in furnishing more calcium than any other common food. This is accordingly one of the standpoints from which milk may be especially evaluated as a dietary essential. The studies of Sherman and Hawley [4] of Columbia University showed significantly that on an ordinary mixed diet containing daily 750 gm. of milk and furnishing a total of from 0.74 to 1.02 gm. of calcium a day, children from 3 to 13 years of age stored from 0.15 to 0.62 gm. of calcium a day, the amount being approximately proportional to the size of the child and averaging 0.01 gm. of calcium per kilogram of body weight, daily. When the daily allowance of milk was increased to 1,000 gm., the storage of calcium was increased. The results obtained indicate that optimal storage of calcium is made when the diet contains 1 quart of milk a day for each child. This, with a normal allowance of other foods, will usually mean a daily intake of at least 1 gm. of calcium for the growing child. According to Sherman, it would be best to maintain this level of milk intake up to at least the age of 12 or 14 years.

In contemplation of advice that seems at length to be based on dependable physiologic information, one is impelled to inquire whether the dictum of "a quart of milk daily" would encounter obstacles in the direction of available supply. Smith [5] regards the possibilities of expansion of the dairy industry as almost unlimited. The world, he has assured us, may have ten or twenty times as much milk as it now has, without any serious reduction of any other food supply. This apparent contradiction comes from the fact that the keeping of cattle is almost a necessary accompaniment of intensification of agriculture. The total production of milk in the United States has been variously estimated at from 0.8 to 1.15 quarts for each person, daily.

How far is the American people from realizing the ideal daily milk consumption that has just been defended? In answer to this question, statistics have recently been compiled by Haven Emerson.[6] According to the Department of Agriculture, in 1900 the nonfarming, that is, the urban and suburban, population of the United States purchased about 0.5 pint of milk per capita daily. In 1920 the amount had risen, according to the same authority, to 0.9 pint, daily. The reports compiled by other organizations interested in public health indicate that the daily per capita consumption varies widely in the larger cities of the country. Several municipalities in various parts of the union report a figure above one pint a day; a larger number indicate much smaller consumption. Geographic conditions do not seem to exert a decisive influence. Thus Detroit, with its high record of 1.3 pints, is approached by Springfield, Mass., with 1.1 pints; while the neighboring city of Worcester reports only 0.39 pint. An almost identical consumption of approximately 0.45 pint is given for New York, Indianapolis, Dallas, Norfolk, Omaha, Savannah and San Antonio. Fifty-two large cities not here included reported a daily milk consumption of from 0.5 to 0.99 pint per capita.

1. Mendel, L. B.: Nutrition, New Haven, Yale University Press, 1923.
2. The "Eat More" Campaigns, editorial, J. A. M. A. **82**: 718 (March 1) 1924.
3. Food and the War, U. S. Food Administration, Boston, Houghton Mifflin Company, 1918.
4. Sherman, H. C., and Hawley, Edith: Calcium and Phosphorus Metabolism in Childhood, J. Biol. Chem. **53**: 375 (Aug.) 1922.
5. Smith, J. R.: The World's Food Resources, New York, Henry Holt & Co., 1919.
6. Emerson, Haven: Per Capita Milk Consumption from the Point of View of the Public Health Officer, Am. J. Pub. Health **14**: 291 (April) 1924.

These figures will suffice to lend some assurance that there still is abundant occasion to increase the use of milk, and large opportunity for the promotion of public health policies in this direction. It is satisfying to have the figures, and encouraging to believe that the current propaganda is well justified.

BLOOD PRESSURE IN EARLY LIFE

During recent years, no medical diagnostic procedure has received such thorough and systematic investigation as has been accorded to the blood pressure and its variations under different conditions and in different persons. This is due partly to the fact that estimation of the blood pressure is not, as a rule, a difficult procedure, and partly also to the fact that material for such studies is always available. The exact facts have not, however, been assembled and sufficiently established, even for the normal, let alone for a vast number of pathologic conditions. It is well, therefore, to have available the results of a statistical study of blood pressure in early life, such as that made in the department of applied statistics in the University of London.[1] The plan of the investigators included a study of the behavior of blood pressure during puberty and adolescence, ascertaining the normal range of systolic, diastolic and pulse pressures at the ages from 5 to 40, and examining the interrelation between these pressures, and their correlation with the various activities of life. Measurements were carried out on 1,633 persons, including 1,323 boys from various schools, forty-two workmen, and 154 male and 114 female college students. As in all medical investigations, it was first necessary to establish a standardized technic. The investigators were promptly convinced of the great superiority of the auscultatory over the palpatory method of determining systolic pressure. The studies included, as well, a survey of the literature on the various points to which special attention was given. The standard technic finally adopted was, briefly, as follows:

> Subject in sitting posture, with left arm resting relaxed on table in front, palm upward; use of sphygmomanometer with standard 12 centimeter armlet applied round left arm above elbow, end of stethoscope being applied by elastic band (not too tightly) to bend of elbow. Readings to be taken as pressure is released; systolic pressure at first and diastolic at fourth point (or "fifth" when fourth is not distinguishable). Where possible, morning readings are advocated.

The investigators found that the changes which occur in pressure and pulse rate on rising from a sitting to a standing posture vary widely in different persons, the average being a rise of 3 mm. in the systolic and 10 mm. in the diastolic pressure, and a rise of 7.5 beats a minute in the pulse rate, with a fall of 7 mm. in the pulse pressure. In females there is, in general, no rise in the systolic pressure, and a rise in the diastolic averages of only 5 mm. It did not seem possible to interpret these reactions in any way as an index of the individual's physical fitness. A study of the changing curves of blood pressure with increasing age indicates that, up to 11 years, the mean systolic pressure rises uniformly with age; during adolescence, the gradient is temporarily increased and the pressure reaches a uniform adult level at about 18 years of age, with no further tendency to rise up to the age of 35 or 40. The diastolic pressure rises more or less uniformly until adolescence, and then more slowly to the age of 17, when it rises rapidly to its maximum about the age of 20. The pulse pressure therefore rises uniformly to 15; during adolescence, rises rapidly to 16 or 18 years of age; rapidly falls to its original level about 20, and then slowly increases up to 40. This is taken as an indication of the fact that the heart is performing more work per unit weight of cardiac muscle during adolescence than at any preceding or subsequent period of life up to the age of 40.

It was found that regular physical exercise tends to keep the diastolic pressure at a lower level by reducing peripheral resistance, thereby rendering the heart more efficient. The psychologic effect on blood pressure is indicated by the fact that average pressures were noticeably higher in schools in which strict discipline was maintained than in those institutions in which the discipline was more easy-going.

Among other by-products of this systematic study was a determination of the relationship of previous infections to changes in blood pressure. The accounts of previous infection with scarlet fever, diphtheria, measles, whooping cough and chickenpox were obtained in the case of 350 boys. As a result, the British statisticians write that it cannot be said that there is any conclusive evidence from these figures of any permanent effect of the exanthems on the systolic pressure in after life.

There still remain many factors related to the blood pressure that require accurate determination. Studies of racial influences and climatic conditions indicate that these may have a bearing in establishing normal figures for certain groups. If a standard technic, subject only to the error of individual determinations, can be generally accepted, the near future may show this diagnostic procedure to have a greater value than is now accorded it.

1. Stocks, Percy; and Karn, M. N.: Blood Pressure in Early Life, London, Cambridge University Press, 1924.

Surgical Treatment of Certain Puerperal Infections.—Puerperal infection, in brief, is simple wound infection, and should be treated on general surgical principles. The puerperal state confers no immunity but rather the reverse. All surgeons recognize the gravity of a neglected palmar abscess, or a wound received in operating or dissecting. Ear specialists long ago learned the vital importance of cleaning out, with ligation if necessary, the thrombosed internal jugular vein in case of lateral sinus infection due to disease of the mastoid; and there is certainly a striking similarity between an infected thrombus in the jugular and the same in the veins of the pelvis.—J. F. Baldwin: *Am. J. Obst. & Gynec.* **5**:511 (May) 1923.

Current Comment

RENAL TISSUE AND BLOOD PRESSURE

Since the days of Richard Bright, the relation between renal disease and arterial blood pressure has been a subject of discussion. There are numerous indications that structural changes in the kidneys cannot be regarded as the sole cause of arterial hypertension. The latter condition often exists without any demonstrable anatomic renal defects; and, conversely, kidney impairment is not invariably attended with augmentation of the blood pressure. Sometimes, however, it is argued that examination of the urine or even histologic observation of the kidneys at necropsy may not always reveal a renal defect; and thus the discussion continues from one decade to another. One might expect that if the gradual rise of blood pressure frequently noted in the course of chronic glomerulonephritis were due to propressive atrophy of renal tissue, as has been asserted,[1] experimental reduction of the kidney mass to the point of actual insufficiency for the usual excretory functions would bring about hypertension. Attempts to demonstrate such an outcome in animals have failed in the hands of Anderson[2] at the University of Minnesota. Removal or destruction of as much as 70 per cent. of the kidney tissue of rabbits did not produce hypertension, even when prolonged renal insufficiency resulted. By inference, then, Anderson concludes, the atrophy of renal tissue in chronic glomerulonephritis is not the cause of the accompanying hypertension.

RADIATION AND THE BACTERICIDAL POWER OF THE BLOOD

However mystifying the physiologic action of sunlight and other kinds of radiation on the human organism may be, there can no longer be any doubt that it is real and sometimes unexpectedly potent. There is an Italian proverb that all diseases come in the dark and get cured in the sun. While this is an exaggeration of the facts of pathology, it embodies an element of hygienic truth. In cloudy climates, the stimulating effect of sunlight on the feeling of comfort and happiness is familiar; no less so is the tiring effect of continual tropical sunlight. Compared with England, for example, the Alps offer the advantage of far more hours of sunlight and a sun richer in ultraviolet rays. In these Swiss highlands, the beneficial effects of exposing the body to open air and sunlight are well known. Surgical tuberculosis and open wounds respond favorably to these environmental influences. A somewhat comparable influence apparently can be exerted by exposure to artificial sources of radiation, as, for example, in the effects of the Finsen light treatment on lupus. The explanation of the curative action in such instances, in which micro-organisms undoubtedly play a part in the pathogenesis of the disease, has not been easy to find. In the Finsen light treatment of lupus, the infecting tubercle bacilli are not killed directly, for the active rays do not penetrate sufficiently to effect this. Hence, it has been assumed that the radiation acts as an irritant to the tissues, resulting in congestion, increased outflow of immunizing lymph, and increased phagocytosis. Tests recently made at the National Institute for Medical Research[1] in London tend to show that any "insult" to the skin, whether produced by ultraviolet and visible rays or by dark heat or by blistering agents, provokes or increases the defensive powers of the body. Its immunizing properties are enhanced. This was observed in bactericidal tests made to determine whether the serum or the leukocytes or both acquire increased power to kill such micro-organisms as staphylococci when man and animals are exposed to radiation and other influences that affect the cutaneous surfaces and produce inflammatory effects there. The London pathologists believe that the absorption into the blood of the products of tissue damage, or the enhanced absorption of normal tissue products produced by such damage and the consequent erythema and edema, may be a "natural excitant" of immunizing reactions, such as are represented by the hemobactericidal power demonstrated by them.

1. Jawein, G.: Berl. klin. Wchnschr. **57**:869, 1920.
2. Anderson, H. C.: The Relation of Blood Pressure to the Amount of Renal Tissue, J. Exper. Med. **39**:707 (May) 1924.

WHERE TUBERCULOSIS IS INCREASING

Before the World War, it seemed likely that the continued combat against tuberculosis would presently find some degree of fruition in a noticeable reduction of the ravages of this disease. In Germany, for example, the death rate from all forms of tuberculosis fell from 219 per hundred thousand in 1899 to 142 in 1914, a decrease of 35 per cent. The unfortunate conditions brought about by the great conflict have served to afford an utterly undesired illustration of an increase in the incidence of this disease. During 1914-1919, the death rate mounted to 212 per hundred thousand. There was a considerable reduction in Germany, as elsewhere, following the epidemics of influenza in 1920 and 1921, but the return to a high proportion of deaths has again become evident. Usually an attempt has been made to ascertain the causes of changing death rates under conditions of improvement, so that the studies would be expected to show what untoward factors had been eliminated and what beneficial influences had been introduced into the life of the population concerned. In the case of Germany, an unexpected opportunity seems to be presented for attempting to ascertain what new detrimental features in the national life may be responsible for the recrudescence of tuberculosis in its former magnitude. Haven Emerson,[2] who has made a personal inspection, which furnished the data just quoted, believes that there are being reproduced in Germany now, as there were between 1916 and 1920, conditions favoring a prevalence of tuberculosis similar to that of a generation ago. While admitting that shortage of proper food may be an important factor in affecting the susceptibility to infection, Emerson does not place

1. Colebrook, L.: Eidinow, A., and Hill, L.: The Effect of Radiation on the Bactericidal Power of the Blood, Brit. J. Exper. Path. **5**:54 (April) 1924.
2. Emerson, Haven: Tuberculosis in Germany, Am. Rev. Tuberc. **9**:191 (May) 1924.

the dietary situation in the first place of responsibility for what has occurred. What is apparent with more convincing evidence in Germany, he says, is the intimacy, continuity and massiveness of infection of both children and adults, made possible and almost inevitable by the conditions of housing and the breakdown of many of the facilities and resources for the segregation of the sick tuberculosis patients from well members of the family. It is true that food conditions have been distressing. Despite such characteristic evidences of unfavorable opportunities for adequate nutrition, other factors receive the foremost blame. Germany, Emerson concludes, is presenting now "a picture of acute spread of tuberculosis, due primarily to uncontrollable insanitary conditions of housing and lack of means to separate the sick from the well."

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

CALIFORNIA

"Poor Whittier."—At a recent local election, the people of Whittier repudiated the terms of an agreement by which Simon J. Murphy built and gave to the community the Murphy Memorial Hospital, a 100 bed hospital which cost approximately $400,000. *California and Western Medicine* states that the osteopaths, chiropractors, Eddyites and other groups one would expect to see cooperating in any attack on scientific medicine and adequate education as a qualification for practitioners, succeeded in carrying their initiative, and that the hospital will now probably become a place for cultists to treat their patients.

Quack Jailed.—The state board of medical examiners' special agent, Carter, recently arrested "Dr. Rex H. W. Albrextondare," whose real name, it is reported, is Henry V. K. Alexandere, for practicing medicine without a license. Alexandere was detained in connection with an investigation of three mysterious deaths, and was also charged, it is said, with obtaining $37,000 from a widow by alleged fraudulent methods. Judge West of Los Angeles, in whose court the trial for violation of the medical practice act took place, sentenced the accused to 180 days in jail and to pay a fine of $600, and expressed his regret from the bench that the statutes restrained him from passing a larger sentence. In 1918, Alexandere was fined $100 in San Francisco for violation of the medical practice act, and a short time later in Los Angeles was arrested for obstruction of the draft law.

CONNECTICUT

Personal.—Dr. Charles J. Bartlett, New Haven, director of the Bureau of Laboratories of the State Department of Health for the last seven years, has resigned, and Mr. P. E. Bransfield has been appointed acting director. The laboratory will be moved from New Haven to Hartford in the near future.

DELAWARE

Board of Health Election.—The recently appointed board of health of Dover organized, May 27, by reelecting Dr. L. August H. Bishop, president; Dr. Edwin S. Anderson, vice president, and Herman C. Taylor, secretary-treasurer. This is the twentieth consecutive year that Mr. Taylor has been secretary of the board.

FLORIDA

Personal.—Dr. Ralph E. Barnes of the Florida Public Health Association was elected president of the Southern Tuberculosis Association at a meeting held at Atlanta, Ga., May 10.

GEORGIA

Physician Arrested.—Dr. Leighton Brown of Macon and Atlanta was arrested recently by a narcotic agent and city detectives of Atlanta while administering morphin to a drug addict, it is reported. Dr. Brown was sentenced in 1922 to nine months' imprisonment for violation of the Harrison Narcotic Law (THE JOURNAL, Nov. 4, 1922, p. 1615).

ILLINOIS

Personal.—Dr. William J. Whiteaker, Harrisburg, has been appointed physician of Saline County succeeding Dr. L. McCormack.——Dr. Freeman J. Scott, Rock Falls, has been appointed city health officer succeeding Dr. Stephen A. Allen.——Dr. Frank N. Wells, Pittsfield, has been elected physician of Pike County.——Dr. William E. Constant, for the past few years in charge of the St. Charles City Hospital, has resigned.——Dr. Jasper M. Adams, Canton, has been appointed county physician.——A complimentary dinner was given to Drs. John H. Gordon and David R. Wilkins, both of Pocahontas, by members of the Bond County Medical Society, June 27. Dr. Gordon is 81 years of age and Dr. Wilkins 69.——At the convocation of the University of Wisconsin, June 23, Dr. Frank Billings, Chicago, was awarded the degree of Sc.D.

Chicago

Monument to Pasteur.—Plans for the erection of a monument in one of Chicago's parks to the memory of Pasteur have been deferred until the autumn. Dr. Frank Billings is head of the executive committee of the campaign.

Dr. McCormick Released from Elgin.—Dr. Charles McCormick, head of a medical college bearing his name (THE JOURNAL, May 17, p. 1616) at 3736 South Michigan Avenue, was remanded to the Elgin State Hospital for the Insane, May 27, by Judge Lindsay, who denied a writ of habeas corpus, but was released from the hospital, June 3, in the Elgin court on a writ of habeas corpus, it is reported.

INDIANA

State Board Arrests Illegal Practitioner.—J. T. Mehrlich, 20 East Eighteenth Street, Indianapolis, recently pleaded guilty in Judge Wilmeth's court to practicing medicine without a license, and was fined $25 and costs. Mehrlich was arrested on a warrant sworn to by the secretary of the Indiana State Board of Medical Registration and Examination (THE JOURNAL, June 14, p. 1977).

Dr. Wishard Honored.—Physicians of Indianapolis gave a testimonial dinner to Dr. William N. Wishard, professor of genito-urinary surgery at the Indiana University School of Medicine, June 13, on the fiftieth anniversary of his graduation in medicine. A portrait of Dr. Wishard, which will hang in the Indiana University School of Medicine, was unveiled by Dr. David Ross. The university recently conferred the degree of doctor of laws on Dr. Wishard.

Gift to Medical School.—A donation of $75,000 has been made to Indiana University, Indianapolis, by Mr. and Mrs. William Coleman for the school of medicine. The gift is in the form of a memorial to their daughter and will be used to endow the chairs of ophthalmology, surgery and gynecology. Under the provisions of the gift, the income from the entire sum will be divided equally among Drs. Frank A. Morrison, John H. Oliver and Orange G. Pfaff, respectively, presidents of the above named chairs. Other gifts of Mr. and Mrs. Coleman are $25,000 to the Methodist Hospital and $10,000 to the Florence Crittenton Hospital.

IOWA

Personal.—Dr. Russell C. Doolittle, Des Moines, is now physician in charge at "The Retreat" sanatorium, Des Moines; Dr. Julia F. Hill will continue as assistant physician. Dr. Gershom H. Hill has disposed of his interest in "The Retreat" to Dr. John C. Doolittle.

Society News.—At a meeting of the Iowa Clinical Medical Society, May 31, Dr. Charles A. Waterbury, Waterloo, was elected president; Dr. Frederick G. Murray, Cedar Rapids, vice president; Dr. Russell C. Doolittle, Des Moines, secretary-treasurer.

KANSAS

Dr. Uhls Found Guilty.—Dr. Kenneth B. Uhls, Overland Park, was found guilty, it is reported, of murder in the second degree in connection with the death of W. E. Gibbs,

owner of stock in a sanatorium operated by Dr. Uhls. The prosecution's case, it is said, was based on circumstantial evidence during a two-day period prior to December 28, during which time the crime was committed.——Dr. Uhls was acquitted by a jury in the district court, May 13, of a charge of being the instigator of a holdup in January.

KENTUCKY

Physician Fined.—Dr. Jesse S. Bean, Louisville, pleaded guilty, it is reported, to violation of the antinarcotic act in Judge Moorman's court recently, and was fined $1,000.

Personal.—At the recent annual meeting of the Kentucky Tuberculosis Association, Dr. Jefferson L. Atkinson, Campbellsville, was elected first vice president, and Dr. James S. Lock, Barbourville, executive secretary.——Dr. Arthur T. McCormack, Louisville, was elected a director of the Kentucky Public Health Association at a meeting in Louisville, May 17.

University News.—Announcement has been made of the gift by the Carnegie Corporation of $20,000, annually for two years, to the University of Louisville Medical Department, while plans are being perfected for raising an endowment fund. The added income will be used largely in developing the department of pediatrics on an academic basis and establishing an academic teacher in that department.——The annual alumni banquet at the Pendennis Club, June 3, was attended by 322 Louisville graduates from twenty states. President A. D. Harmon of Transylvania University and Prof. Haven Emerson of Columbia University gave addresses.——Dr. Richard Buetner of the University of Leyden, formerly of the Rockfeller Institute, has been appointed assistant professor of pharmacology in the University of Louisville Medical Department.

MARYLAND

Gift to Church Home and Infirmary.—By the will of Frank P. Woodside, the Church Home and Infirmary, Baltimore, has been given $50,000 worth of Baltimore city 4 per cent. stock. The legacy is a memorial to Mr. Woodside's parents and is to be used to provide a room for free patients.

Personal.—Dr. Lilian Welsh, Baltimore, for thirty years professor of physiology and hygiene at Gaucher College, was given the honorary degree of LL.D. at the recent commencement on the occasion of her retirement from teaching. Dr. Welsh becomes professor emeritus.——Dr. Ernest Carroll Faust, in charge of the division of parasitology, Peking Union Medical College, who has exchanged chairs in helminthology during the year 1923-1924 with Dr. William W. Cort, Johns Hopkins University School of Hygiene and Public Health, will return to Peking, July 31, to continue investigations of the biology and epidemiology of parasitic diseases in China.

MASSACHUSETTS

Chiropractor Arrested.—M. B. Du Lysle, chiropractor, Marlboro, was sentenced to two months in the House of Correction by the superior criminal court, May 8, for practicing medicine without a license, it is reported.

State Medical Meeting.—At the one hundred and forty-third annual meeting of the Massachusetts Medical Society at Swampscott, June 6-7, Dr. Enos H. Bigelow, Framingham, was elected president; Dr. Ralph W. Jackson, Fall River, vice president; Dr. Walter L. Burrage, Brookline, secretary; Dr. Arthur K. Stone, Framingham, treasurer; Dr. Edwin H. Brigham, Brookline, librarian emeritus, and Dr. David Cheever, Boston, orator. The president, secretary and treasurer were reelected.

MICHIGAN

Chiropractors Held.—Five chiropractors and a naturopath were arrested by the police of Lansing recently and charged with practicing medicine without a license. They were C. A. Turner, Mrs. D. E. Turner, C. D. Desmore, Leon Foster, Floyd Welcher and H. J. Ketchum. They were released on personal recognizance, their cases being continued.——M. H. Beebe, Grand Rapids, a chiropractor, recently fined $25 and costs for using the title "Doctor," refused to pay the fine and was given thirty days in jail.——W. W. Erdman, Big Rapids, chiropractor, convicted, recently, of practicing medicine without a license, was sentenced by Judge Barton to serve three months in jail and to pay a fine of $200, the provision being made that Erdman continue to serve time not to exceed six months until the fine is paid.

MINNESOTA

Health Touring Car.—The state public health association has recently purchased a special automobile equipped as a clinic and demonstration car to tour the state in the campaign for the prevention of disease and preservation of health. Dr. O. C. Lockhead, field secretary of the association, will be in charge of the car.

Hospital News.—The Elk River Hospital has suspended operations because of lack of patronage.——Work has been resumed on the building of the Ashton Memorial Hospital at Pipestone.——The new Wilder Dispensary Building, erected in St. Paul by the Amherst Wilder Charity at a cost of $200,000, is ready for occupancy. It is a four-story brick and stone structure.

MISSOURI

Personal.—Dr. James W. Boger, Sedalia, county health officer of Pettis County, has resigned.——Drs. Fred W. Bailey and William Engelbach, both of the St. Louis University School of Medicine and on the staff of the St. John's Hospital, have tendered their resignations from the faculty and hospital.

Department of Medicine on Full-Time Basis.—According to announcement made by Dean Loeb at the commencement exercises, the St. Mary's group of hospitals, comprising 600 beds, of which 200 are free, has by agreement become the University Hospital of the St. Louis University School of Medicine, the university having full control of the medical and educational activities. The first step in the complete establishment of this relationship has been the organization of the department of medicine on a full-time basis. In addition to the instructors who have been previously conducting the department, the following full-time physicians have been appointed: Ralph A. Kinsella, professor of medicine and director of the department, formerly associate professor and acting head of the medical department of Washington University; Goronwy O. Broun, associate professor of medicine, formerly instructor in medicine at Harvard University and resident physician at the Boston City Hospital; Charles H. Hitchcock, assistant professor of medicine; Alfred P. Briggs, instructor in medicine, and Octavio Garcia, instructor in medicine.

NEW JERSEY

Personal.—Dr. Charles B. P. Kelley, Jersey City, president of the Hudson County Medical Society, has been appointed a member of the state board of medical examiners, to fill the vacancy caused by the death of Dr. John J. Mooney and for the full term, beginning July 1.

NEW YORK

University Fellowship.—The Cornell University Traveling Fellowship in Medicine for the year 1924-1925 has been awarded to Dr. Arthur M. Master who obtained his M.D. degree from that institution in 1921. This fellowship was designed to aid men and women who desire to continue the study of medicine abroad, and is available for physicians who have graduated from Cornell within ten years and men and women graduated from other medical schools within ten years and who are now attached to the instructing staff of Cornell University. This year the scholarship amounts to $2,000.

State Health Department.—In addition to its monthly publications, the *Health News, Public Health Nurses' Bulletin* and *Health Officers' Bulletin*, the New York State Department of Health is publishing a *Quarterly*, the April issue of which has just appeared, giving in brief a review of the department for 1923. A new feature of the work of the division of public health education is the radio talks. This service continued throughout the year, a health talk being given every Friday evening with two exceptions. Each talk was released for the newspapers of the state on the Saturday following the broadcast. The number of clippings received indicate that 10 per cent. more papers used the health talks during 1923 than during the previous year, 44 per cent. of all papers using the talks during 1923. Additional news letters on health topics sent to the newspapers were used by 46 per cent. of the papers to which they were sent. The most gratifying feature of the year was the reduction in the morbidity and mortality from diphtheria. The mortality for the first time dropped below 10 per hundred thousand population. The fatality rate, 6.4 per cent., was 0.4 per cent. below the lowest previous record. An important factor contributing to the reduced mortality was undoubtedly the educational effect on the laity of the toxin-antitoxin campaigns and the education of physicians incidental to the investigation of fatal cases.

New York City

Postgraduate Course in Gastro-Enterology.—A four weeks' graduate course in gastro-enterology will be given by Columbia University at Vanderbilt Clinic, from July 2-30, and a similar course, from August 1 to 27. Dr. John L. Kantor will be the instructor.

Seaside Clinic Opens.—The Seaside Clinic of the department of health at Coney Island was opened, June 17, by formal exercises in which the mayor and Health Commissioner Frank J. Monaghan took part. This clinic has been so popular it has been decided to establish similar ones at Rockaway Beach and South Beach, Staten Island.

Committee on Periodic Examinations.—At the stated meeting of the Medical Society of the County of New York, May 26, a resolution was passed calling for the appointment of a committee through which the society may formulate a plan to promote periodic health examinations through the agency of the general practitioner. The president appointed a committee of eleven members, with Dr. Orrin S. Wightman as chairman.

Cornell Commencement.—The twenty-sixth annual commencement of Cornell University Medical College was held, June 11. President Livingston Farrand conferred the degree of Doctor of Medicine on fifty-eight candidates. The John Metcalf Polk prize of $300 was awarded to Miss Evelyn Holt of Summit, N. J. She has been appointed an intern in the New York Hospital, being the first woman to receive this appointment.

"Dr." Giovannantonio Jailed.—Judge Bleakley of the county court sentenced J. Di Giovannantonio of Ossining to six months in the Westchester penitentiary, on his plea of guilty to a charge of practicing medicine without a license. Giovannantonio claimed that he is a graduate of an Italian medical school and a former Italian army surgeon. He produced a certificate bearing the initials "D.C," which he claimed was obtained from an institution in Chicago.

Internships in Contagious Disease Hospitals.—The public health committee of the New York Academy of Medicine has passed a resolution to the effect that all interns in general hospitals should have a brief internship in a hospital for contagious diseases. The city department of health will cooperate with the general hospitals by making provision for such internships in the city contagious hospitals. The resolution further states that the committee views with favor the opportunities afforded at Willard Parker Hospital whereby nurses receive special training in the care of communicable diseases.

Clinical Stomatology Journal and Clinic.—Announcement has been made of a new journal, the *Review of Clinical Stomatology*, a monthly devoted to the advancement of knowledge of diseases of the mouth and teeth, and a supplement to the *Journal of Ophthalmology, Otology and Laryngology*. The staff comprises Alfred Asgis, D.D.S., New York City, and Dr. George W. Mackenzie, Philadelphia, editors; and Dr. William G. Shemeley, Philadelphia, and Walter B. Veazie, Ph.D., University of Colorado, associate editors.—— The Midtown Hospital, New York City, has provided the necessary facilities for clinics for the treatment of pyorrhea, the extraction of teeth, and for oral surgery.

NORTH CAROLINA

License to Practice Surrendered.—Dr. Harvey Robinson, Chadbourn, recently pleaded guilty, it is reported, to charges of selling narcotics, and was required by Judge Groves to surrender his license to practice medicine.

Personal.—Dr. Lewis B. McBrayer, Sanatorium, secretary North Carolina State Medical Society, has recently been elected chairman of the board of directors of the North Carolina State Odd Fellows Orphanage of which board he has been a member for several years.

County Health Departments.—Wayne County established a record in results in public health work for the recently ended quarter; according to the Rankin-Cost-Equivalent system it earned $3.73 for each dollar expended, during the previous three months. Sampson County previously held the record with $2.57 earned for each dollar expended. North Carolina now has thirty-two whole-time county health officers with organized county health departments functioning.

OHIO

Chiropractors Jailed.—Ben L. Miles, president of the Ohio Society of State Chiropractors, and A. C. Humphrey, chiropractor, were recently fined $200 and costs for practicing medicine without a license, it is reported. They preferred jail to paying the fines, and will be kept there for 333 days. Ellis W. West and Harriet A. Clemens were fined similar amounts on like charges, but announced that they would appeal their cases.

Cleveland Schools Negotiate for Merger.—It is reported that negotiations are in progress to bring about a merger of Western Reserve University with other institutions in Cleveland to form a University of Cleveland. These include the Case School of Applied Science, the Lakeside Hospital, the Maternity Hospital and the Babies' Hospital, the Cleveland Museum of Natural History, the Cleveland School of Art, the Cleveland Museum of Art and the Western Reserve Historical Society Museum. It is planned to raise an endowment fund of $20,000,000.

PENNSYLVANIA

In Practice at Eighty.—A dinner was recently given in honor of Dr. James E. Silliman, Erie, on the occasion of his eightieth birthday. Dr. Silliman, who is still in active practice, is said to be the only physician in Erie who has not discarded the horse and buggy for making professional calls.

Bureau of Mental Health.—Thirty-one mental health clinics are being held regularly in different parts of Pennsylvania according to a recent bulletin of the Bureau of Mental Health, State Department of Welfare. Psychologic and social service are supplied for these clinics by both the local communities and the Bureau of Mental Health, and the consultants for the clinics are secured from the various schools for mental defectives and hospitals for mental diseases. Dr. David J. Philips, Jr., formerly mental health officer, Illinois State Penitentiary, Joliet, has been appointed by the bureau as criminologist. He is stationed at present at the Eastern State Penitentiary, Philadelphia, from which place he goes to the various other state correctional institutions for consultation.

County Tuberculosis Hospitals in Pennsylvania.—The people of fourteen counties have voted by referendum to establish county tuberculosis hospitals. In some instances, little has been done by the county commissioners to carry out the mandate of the voters. The following counties have hospitals in operation:

Allegheny (Woodville). Allegheny County exclusive of Pittsburgh. All classes. 150 beds. All free.

Beaver (Monaca R. D. 1). Beaver County. Pulmonary tuberculosis. All stages. 49 beds. Some free. $1 to $21 per week, according to ability of patient to pay.

Berks (Neversink Mountain). Berks County. All stages. 40 beds. Free for those who are unable to pay. Up to $3 per day according to means.

Lackawanna (West Mountain, outside of Scranton). Lackawanna County. Moderately advanced and incipient. 50 beds. All free.

Lancaster County will soon have a county tuberculosis hospital. The Anti-Tuberculosis Society of Lancaster has purchased the Hotel Rossmere on the outskirts of the city and is transforming it into a sanatorium. Sites have been purchased in Luzerne and Cambria County. Available sites are being canvassed in Dauphin, Delaware, Erie and Montgomery counties. In two counties, Mercer and Northampton, no definite action has been taken, although the people voted in favor of establishing tuberculosis hospitals.

Philadelphia

Personal.—Dr. Chevalier Jackson, professor of bronchoscopy and esophagoscopy in the Jefferson Medical College of Philadelphia, was a guest of honor of the Kiwanis Club at a luncheon in the Bellevue-Stratford, June 9, and was award the Kiwanis medal, as rendering the highest service to his fellowmen during the last year.

Gifts to College of Physicians.—At a meeting of the College of Physicians, June 4, Dr. W. W. Keen presented a portrait of Dr. William J. Taylor on behalf of his friends; Dr. William H. Welch, Baltimore, transferred the custodianship of the Cabinet of Historic Medical Mementos to Dr. Keen, who made also the presentation on behalf of Sir W. Hale White, president of the Royal Society of Medicine, London, of a facsimile of notes on lectures on anatomy in Guy's Hospital in which John Keats was a dresser in 1816.

New Hospital at Blockley.—The erection of a new 2,100 bed hospital to replace the present Philadelphia General Hospital was made possible by the action of the council's committee on public health, June 12. The committee approved the ordinance setting aside $4,000,000 from the next municipal loan for the razing of the present buildings and the erection of the new institution. The appropriation will make it possible to remove all the 1,400 insane patients now at

Blockley to the City Hospital for the Insane at Byberry. The old buildings now occupied by the insane will be demolished; new buildings erected to house the medical and surgical cases, and, ultimately, all the antiquated structures removed.

SOUTH CAROLINA

Board of Health Elections.—At a recent meeting of the board of health of Charleston, Dr. William H. Price was elected chief food inspector for the city, and Jack C. Norris, assistant city bacteriologist.

Personal.—Dr. Charles H. Pate, Bishopville, has been appointed health officer of Henderson County and Hendersonville.—Dr. Jean B. LaBorde has resigned as city health officer of Columbia, effective July 1.

TENNESSEE

Hospital News.—A group of Knoxville physicians, of which Dr. H. E. Goetz is chairman, is planning to develop the Neubert Springs hotel property into a sanatorium and hotel, at an expenditure of $150,000.

Society News.—At the fifty-ninth semiannual meeting of the Middle Tennessee Medical Association at Columbia, May 15-16, Dr. Harrison H. Shoulders, Nashville, was elected president; Dr. James C. Kelton, Lascassas, vice president, and Dr. Sam P. Bailey, Nashville, secretary-treasurer. The next meeting place will be Lewisburg.——The West Tennessee Medical and Surgical Association met at Jackson, May 22-23, under the presidency of Dr. Jesse P. Baird, Dyersburg. The officers for the ensuing year are: president, Dr. B. J. Gillespie, Covington; vice presidents, Drs. William W. McBride, Gleason, and G. Weldon Oliver, Medina, and secretary, Dr. Isaac A. McSwain, Paris. The next meeting will be held at Paris.

TEXAS

Personal.—Dr. George A. McBride has been appointed health officer of Harlingen.——Dr. James Mackins has been appointed head of the bureau of communicable diseases of the state board of health.——Dr. Edmond C. Hancock, Arlington, has been appointed physician to the Home for Aged Masons, Arlington.

Beneficiaries of the U. S. Public Health Service.—In a report of the Texas member of the National Legislative Council at the recent meeting of the state medical association, Dr. Murff F. Bledsoe, Port Arthur, drew attention to the activities in the treatment of private citizens by the U. S. Public Health Service. He said the following are beneficiaries of the Public Health Service, and are treated by its medical force:

Those employed on board in the care, preservation or navigation of any registered, enrolled or licensed vessels of the United States, or in the service on board on those engaged in such care, preservation or navigation.
Seamen employed on U. S. Army transports or other vessels belonging to the U. S. Army when not enlisted men of the army.
Seamen employed on yachts, provided the said yachts are enrolled, licensed or registered as vessels of the United States.
Officers and enlisted men of the U. S. Coast Guard.
Officers and employees of the U. S. Public Health Service.
Seamen employed on the vessels of the Engineer Corps of the Army.
Officers, crews of vessels, keepers and assistant keepers of the Lighthouse Service.
Officers and seamen on vessels of the Coast and Geodetic Survey.
Civil employees of the United States who are injured while in the performance of their duties.
Officers and crew of vessels of the Bureau of Fisheries.
Patients of the Bureau of War Risk Insurance.
Patients for special study and investigations; and
Immigrants and immigrant seamen and foreign seamen are also entitled by courtesy to examination and treatment by this service, at the request of the immigration authorities or the consul of the country concerned.

WISCONSIN

Personal.—The governor has appointed Dr. Mina B. Glasier, Bloomington, one of the seven members of the state board of health. Dr. Glasier has been secretary of the Grant County Medical Society for many years.——Elliot R. Downing, Ph.D., associate professor of natural science, University of Chicago, addressed the Physicians and Surgeons Club of Beloit at its regular meeting, May 13.——Dr. Clark W. Voorus has been elected health officer of Beaver Dam.

CANADA

A Lister Memorial.—The Canadian Medical Association two years ago decided to establish a triennial oration in honor of Lister. As a result of the deliberations of the committee appointed to consider the question it has been decided to ask the members of the association for contributions. The sum considered necessary is $5,000 the interest on which in three years, it is thought, would be sufficient to defray the expense of bringing some distinguished visitor to Canada. Dr. John Stewart, Halifax, delivered the first Listerian oration at the recent meeting of the association in Ottawa. Checks may be sent to Dr. F. N. G. Starr, 112 College Street, Toronto.

Personal.—Dr. Robert A. Pyne has been appointed sheriff of Toronto.——Dr. William E. Gallie, assistant professor of clinical surgery, University of Toronto Faculty of Medicine, recently delivered the first of the series of Hunterian lectures before the Royal College of Physicians and Surgeons of London, England, on "The Use of Living Sutures."——Dr. Robert T. Rutherford, formerly medical inspector of immigration for Canada at Ellis Island, N. Y., is now quarantine officer for the Canadian department of health, with headquarters at Partridge Island, St. John, N. B.——Drs. John G. McDougall and William H. Hattie were reelected president and registrar, respectively, of the provincial medical board of Nova Scotia at the annual meeting, May 9.——Dr. Phileas H. Bedard, Montreal, has received the rosette of the French government for his services as public instruction officer.——Dr. L. P. Ereaux, a graduate of McGill University Faculty of Medicine, has been appointed medical officer to the Laurentide Health Service, Grand Mere, Ont.——Prof. John J. R. Macleod, University of Toronto Faculty of Medicine, addressed the Essex County (Ont.) Medical Society on "Respiration and Acidosis," recently.——Prof. E. M. Watson has been appointed lecturer on pathologic chemistry at the Western University Faculty of Medicine, London, Ont., and consulting pathologist for Victoria Hospital.——Dr. Thomas R. Ponton, former superintendent of the Vancouver General Hospital, has accepted the superintendency of the Hollywood (Calif.) Hospital.

GENERAL

American Pediatric Society.—At its thirty-sixth annual meeting in Pittsfield, Mass., June 5-6, the American Pediatric Society elected the following officers: president, Dr. John Ruhrah, Baltimore; vice president, Dr. Fritz B. Talbot, Boston; secretary-treasurer, Dr. Howard C. Carpenter, Philadelphia.

Colloid Symposium.—The Second National Colloid Symposium was held at the Northwestern University, Evanston, Ill., June 18-21. Friday, June 20, the evening meeting was held in cooperation with the Chicago Section of the American Chemical Society at the City Club, Chicago. A movement to raise an endowment of $1,000,000 for a national institute of research in colloid chemistry has been approved by the National Research Council and the National Academy of Science.

International Conference on Health Problems in Tropical America.—A conference on health problems in tropical America is to be held under the auspices of the medical department of the United Fruit Company, July 22-August 7, at Kingston, Jamaica. The program, which will be participated in by authorities on tropical disease and by special representatives of important medical organizations, includes manuscripts on almost every health problem involved in tropical medicine. In addition to the scientific program, arrangements have been made for many social events, including an official dinner, a tour of hospitals and plantations and a visit to Guatemala City.

Pacific Coast Oto-Ophthalmological Society.—This society will hold its twelfth annual meeting, July 10-12, 1924, at Portland, Ore., under the presidency of Dr. Frederick A. Kiehle of that city. The guest of honor will be Sir John Herbert Parsons of London, England, to whom a complimentary dinner will be given, July 9, by the faculty of the School of Medicine of the University of Oregon, and who later will deliver a public address on "The Role of Ophthalmology." Sir John will address the society, July 10, on "Iridocyclitis" and again at the annual dinner the evening of July 11 on "Retrobulbar Neuritis."

Society News.—At the convention of the Medical Society of Virginia, the Medical and Chirurgical Faculty of Maryland and the Medical Society of the District of Columbia in Alexandria, Va., May 21, Dr. Howard Fletcher, Warrenton, Va., was elected president for the ensuing year; Dr. George T. Klipstein, Alexandria, Va., first vice president; Dr. Thomas M. Foley, Washington, D. C., second vice president; Dr. Robert S. Lamb, Washington, D. C., treasurer; Dr. William T. Davis, Washington, D. C., recording secretary, and Dr.

Joseph D. Foley, Washington, D. C., corresponding secretary. Washington, D. C., was chosen for the next semiannual convention of the societies in November.

Medical Library Association.—The twenty-seventh annual meeting of the Medical Library Association was held in Chicago, June 9-10. Papers were read by J. Christian Bay of the John Crerar Library; C. Perry Fisher, College of Physicians of Philadelphia; Janet Greene of the Hospital Library and Service Bureau; Carl H. Milam, secretary of the American Library Association; Col. C. F. Wylde, McGill University Faculty of Medicine, Montreal, Que., lecturer in medicine and clinical medicine and demonstrator in pediatrics; Dr. Leroy Crummer, professor of internal medicine, University of Nebraska College of Medicine, Omaha; Margaret Brinton of the Mayo Clinic Library, and William Bebb, D.D.S., Northwestern Dental School, Chicago.

Malaria Menaces Europe.—The health organization of the League of Nations has sent commissions at the request of the governments of Greece and Albania to study the malaria situation in those countries, and will shortly send a similar commission to Persia. According to the minister of health of Greece, 2,000,000 people in that country, or about one-third of the population, are affected with malaria. It is also reported that a total of 4,800,000 cases of malaria have been reported in Russia, in which country the Ukraine is the most severely affected. There is a scarcity of quinin in these countries, and an international conference to devise means of increasing the supply is under consideration. The total annual production of quinin at present is said to be about 600 tons.

Tuberculosis Exhibit at Smithsonian Institution.—A tuberculosis exhibit, which will be part of the permanent exhibit of the National Health Council at the Smithsonian Institution, Washington, D. C., has been made for the National Tuberculosis Association by Dwight Franklin of New York. There are five groups in the exhibits, each about 18 inches high and 24 inches wide; the wax figures are about 8 inches high. The groups bear the legends: 1. Overwork, insufficient food, impure air, and lack of exercise cause tuberculosis. 2. Early diagnosis at a tuberculosis clinic increases the chances of recovery. 3. The tuberculosis nurse teaches the family how to prevent further infection. 4. Tuberculosis can be cured; the sanitarium is the best place to take the cure. The fifth is a modern health crusade group.

Shriners' Hospital for Crippled Children.—The fifth Shriners' Hospital for Crippled Children was dedicated in St. Louis, June 1; the others in operation being at San Francisco, Portland, Ore., Shreveport, La., and Minneapolis. It is reported that the Shrine proposes to build at least twenty such hospitals, so that one will be within a reasonable distance of any crippled child in this country, who may receive treatment regardless of creed or race, the only restrictions being that the ailment must be in the field of orthopedic surgery and offer reasonable hope of cure, and the parents financially unable to pay for treatment in other hospitals. Each Shriner is assessed $2 a year for this fund. Hospitals are being constructed in Montreal, Canada, and Springfield, Mass., and hospital sites have been purchased in Philadelphia and Chicago.

Health Education Scholarships.—The committee on awards of the American Child Health Association met in New York, June 2, and selected fifty teachers as prize winners of $500 scholarships in health education in forty-seven cities throughout the country. There were 1,639 competitors who submitted examples of classroom work in health education directed by them during the school year. The contest was made possible by an appropriation of $25,000 by the Metropolitan Life Insurance Company. The decisions of the committee on awards were determined by the examples of work submitted, by the teachers' records, and by their achievements in carrying health education into homes and in arranging for the correction of physical defects of pupils. These scholarships will afford the winners an opportunity to study courses correlated with health education, including nutrition, biology, psychology, sociology and education, at one of the leading universities.

Safety in Oil Fields.—An investigation of safety conditions in the oil fields of the country is being made by the Department of the Interior, through the bureau of mines. It is the intention of the bureau to keep in touch with officials and safety engineers employed by oil companies, by correspondence and personal visits, and to encourage and advise them about measures that will strengthen the safety work at their properties. The bureau will gather information from the properties visited regarding methods and devices used to increase safety; take photographs to illustrate safety articles and bulletins showing safe and unsafe practices; gather and publish accident statistics, and disseminate among operators, foremen and workmen, by personal visits, the arguments for increased safety in the oil industry. A bulletin on the draw works, rotary table and drilling engine safeguards has been completed and will soon be published, and another on safeguarding the derrick is in preparation. Other safeguards and safety devices will be studied and the findings published from time to time.

Trachoma Campaign Among the Indians.—A crusade to eradicate trachoma among the Indians of Arizona and New Mexico will be inaugurated, July 1, under the direction of a special physician of the Indian Office assisted by surgeons of the U. S. Public Health Service, it was announced at the Interior Department, June 17. The campaign known as the Southwestern Trachoma Campaign grew out of the recent trip made by Secretary of the Interior Work and Commissioner Charles H. Burke of the Bureau of Indian Affairs to survey health conditions among Southwestern Indians. A conference recently held between Dr. John McMullen, surgeon, U. S. Public Health Service, and a committee appointed by the Indian Office, resulted in the completion of plans. Dr. James S. Perkins, special physician in charge of the states of Arizona and New Mexico, will direct the movement to stamp out trachoma. Temporary trachoma hospitals will be established in Indian school buildings unoccupied during the vacation period. There will be three operating units that will go into the field, each headed by a special physician with a crew of Indian employees sufficient to carry on the work of examining and treating Indian patients suffering with trachoma efficiently and expeditiously. The three units will begin work at Fort Defiance on the Navajo jurisdiction and from there will proceed to other jurisdictions. Trachoma nurses will be employed and assigned to various schools and stations for carrying out the after-treatments prescribed and all necessary medical supplies and equipment will be furnished by the Indian Office. Dr. Polk Richards, Fort Defiance, Ariz., has been designated as consulting ophthalmologist for the campaign, which is the first of its kind to be conducted by the government against trachoma among the Indians. Similar groups of medical experts will be organized later by the Bureau of Indian Affairs to extend the work of eradicating trachoma to other reservations.

Bequests and Donations.—The following bequests and donations have recently been announced:

American Pharmaceutic Association, $300,000, in the campaign for funds for the new headquarters building.

Northwestern University, Chicago, $250,000, for the George R. Thorne Memorial Auditorium, by Mrs. Thorne.

Philadelphia Home for Incurables, $105,000, by Mrs. Maggie Crawford.

Silver Cross Hospital, Joliet, Ill., $100,000, by the will of Charles Pettigrew.

Jewish Hospital, Philadelphia, $32,000, by Mrs. Odella S. Ellis, for a nurses' home in memory of her mother, and $25,000, by Mrs. Harry Miller.

The New Brunswick Hospital, St. Peters General Hospital and the Middlesex General Hospital, N. J., $11,000 each, by the Elks Club.

Huntsville, Ala., towards the erection of a hospital, $10,000, for the establishment of five memorial rooms, in memory of his family, by Thomas T. Terry.

The Charity Hospital, New Orleans, $5,000; the Orphan Asylum and the Louisiana Commission for the Blind, $2,000 each; the Child Welfare Association, Little Sisters of the Poor, the Hotel Dieu, Touro Infirmary, the Convalescent Home, the Tuberculosis League, the Milne Home for Feebleminded, and the Chinchuba Deaf and Dumb Institute, each $1,000, by the will of Edward A. Larose.

The Brooklyn Hebrew Orphan Asylum, $5,000; the Brooklyn Federation of Charities, $2,500, and the New York Skin and Cancer Hospital, $1,000, by the will of Rachael Lublin.

The Staten Island (New York) Hospital and the Richmond County Society for the Prevention of Cruelty to Children, each $5,000, by the will of George T. Bonner.

The Babies' Hospital, Philadelphia, $5,000 a year for the maintenance of an outpatient obstetrical department, by Mrs. Edward T. Stotesbury of Philadelphia.

The Lenox Hill Hospital, New York City, $5,000, by the will of George P. Lies.

The Nursery and Child's Hospital, Baltimore, $4,000, by the will of Mrs. Carrie Simson.

The Montgomery Hospital, Norristown, Pa., $1,000; the Samaritan Hospital, the Philadelphia Home for Incurables, St. Joseph's Hospital, the Northwestern General, the Roosevelt hospitals, the Woman's Homeopathic Association, the Woman's Hospital and the Children's Homeopathic Hospital, each $5,000, and at the death of the beneficiaries, $10,000 each to the American Oncologic Hospital and the Northwestern General Hospital, Philadelphia, by the will of Mrs. Catherine Wentz.

Jamaica Hospital, Jamaica, N. Y., $1,000, for the establishment of a room to be known as the Roosevelt Auxiliary room by the auxiliary.

Children's Aid Society, a sixty-three acre farm at Balhalla, N. Y., for the accommodation of fifty convalescent boys, by Dunlevy Milbank, in memory of his father.

Dutchess County, N. Y., a seventy-five acre farm near Freedom Plains for a summer health camp, by the Elks.

Graham, Texas, the site and half the necessary building amount for a community hospital in that city, by M. K. Graham.

Bashor Deaconess Orphanage, Goshen, Ind., 370 acres, by Mr. and Mrs. William Bashor.

Beardstown, Ill., land for a hospital site, by Dr. Henry Ehrhardt.

Out of the $65,532 Rosenfeld Trust Fund, Mr. and Mrs. Ernst Rosenfeld will equip a department of radiotherapy and purchase radium for Mt. Sinai Hospital, New York City.

Hospital for Joint Diseases and the Montefiore Hospital, New York City, in commemoration of its sixtieth anniversary, the Progress Club has endowed a bed in each of these institutions.

Northwestern General Hospital, Philadelphia, the endowment of four beds and a fully equipped ambulance by the Order of Artisans.

Newton, Iowa, her former residence, to be used for a hospital by the will of Mrs. William R. Manning.

Rush Medical College, Chicago, his surgical instruments and library, by the will of the late Dr. John Mandeville.

James W. Sheldon Memorial Hospital, Albion, Mich., a roentgen-ray machine, by Dr. George C. Hafford.

LATIN AMERICA

Leprosy in Panama.—Dr. Joseph S. Ergas, superintendent of the government charity hospital at Bocas del Toro, writes that in the last six months eight patients with leprosy in the republic of Panama have been sent to the leprosarium at Palo Secco. There are many other patients, he says, still "loose" in various parts of the republic, but measures are being taken to have them isolated.

FOREIGN

Magazine for Blind Children.—The *School Magazine*, a braille magazine for blind children, has been established in England. It contains essays, poetry, humor and a competition page.

Motor Insurance for Physicians in England.—The Medical General Insurance Association Limited of London issues a special policy for physicians at less than the usual rates. It covers accidents, theft, fire, and compensation for loss of fees through bodily injury. The lower rate to physicians is possible, it is stated, because physicians on the average are better qualified drivers than the general public.

Mental Hygiene in Hungary.—The latest country to organize a national society to promote the mental hygiene of its citizens is Hungary. The society was recently organized in the house of parliament at Budapest under governmental auspices, in the presence of the secretary of state, the minister of public welfare, members of the nobility and numerous representatives of the medical profession. Sponsors of the league included the regent of Hungary, Admiral Horthy, the primate of Hungary and many other prominent Hungarians.

Belgium's Need of Physicians for the Colonies.—The *Bruxelles-médical* remarks that the ten years of guaranteed service for physicians for the colonies would attract many physicians if it were not for the fear of what might follow when the ten years are ended. They return to practice in the home land, but are unable to find a footing. The editorial suggests that if a post were guaranteed in some branch of the state service on their return, there would be many more candidates for the colonial positions. A similar law is already in vogue reserving certain positions for ex-soldiers.

French Pension Scandal.—A group of physicians and others at Marseilles have been convicted of fraud in regard to pensions for war-wound disability. The *Marseille médical* gives the list of seven physicians who have been sentenced to prison for terms of from six months to two years, deprived of the right to practice for from four to ten years, and fines imposed of from nearly 4,000 to nearly 134,000 francs, to be paid to the state, other fines to the Veterans' Union, and a nominal fine of 1 franc to the local medical syndicate. Two health officers and some pharmacists are also penalized, and the soldiers involved are given from six months to four years in prison and fined from 2,000 to 4,000 francs.

Medical Expedition to the South Seas.—An expedition sent from the London School of Tropical Medicine to the Samoan Islands in 1921-1922 has made a preliminary report. Twenty islands were surveyed in the Samoan, Tokelau and Ellice groups. It was stated that the prevalent diseases are ancylostomiasis, filariasis, yaws, tuberculosis and skin affections, especially tinea imbricata. Leprosy was found in the Samoan group and many cases of fish poisoning in the Southern Ellice Islands. In Samoa, of 2,509 persons past their sixteenth year, 58.3 per cent. showed evidence of filarial infestation; 115 cases of elephantiasis were seen; the percentage of ancylostome infection was 85.1. Gonorrhea seemed to be exceedingly rare.

Hospital for Japan.—A portion of the relief fund of the American Red Cross, given to the Japanese Red Cross at the time of the earthquake last autumn, has been set aside for the building of a hospital, the name of which is to be "Neighbor Love Memorial Hospital Foundation" (Do ai kinen byoin sai dan), to commemorate American generosity and sympathy. The necessary charter has been obtained from the department of the interior, and a committee has been appointed, composed of the vice minister of home affairs (chairman); the chief of the department of health; the chief of the bureau of intelligence on Europe and America (a subdivision of the bureau of foreign affairs) and two professors of medicine, one from Tokyo University and one from Keio University. An advisory board of ten members is to be selected from prominent representatives of the medical profession in Japan. The building and equipment are to cost $1,500,000; another million and a half has been invested in bonds of the city of Tokyo, and the interest will be used for maintenance. The hospital will have a capacity of from 200 to 300 beds, and will be ready to receive patients at this time next year.

The International Urologic Congress.—The first meeting of the International Urologic Society since its reorganization after the war was held at Paris in 1921, and the second meeting has just been held at Rome. Professor Alessandri presided. The three topics selected for discussion were "Denervation of the Kidneys"; "Vaccine Therapy in Non-gonorrheal Urinary Affections," and "Remote Results of Operations for Calculi in Kidneys and Ureters." Removal of the sensory nerve fibers in the pedicle of the kidney, in treatment of rebellious pain in the kidney, elicited a lively discussion, and Legueu reported excellent results without apparent injury of renal function. Ambard has apparently demonstrated in animals that the denervated kidney keeps pace functionally with its sound mate. The reports on protein therapy and vaccine therapy in urinary affections were conflicting, although Rovsing reported 85 per cent. cured or materially improved by an autogenous vaccine in 222 cases; 15 per cent. were refractory. Pirondini suggested that it might be well to supplement the vaccine made from the urine with a vaccine made from the primary focus elsewhere, in teeth, skin, tonsils, genital organs or colon.

Medical Journal Offers Prizes.—The directors of the *Medical Journal of South Africa* have decided to offer prizes for the three best essays submitted to them on or before December 31, the subjects to be (*a*) "Dental Caries in Native Children in Kraals and in Urban Areas"; (*b*) "Frequency of Infestation with and Pathologic Conditions Due to Intestinal Parasites Among Europeans and Natives in South Africa and the Treatment of These Conditions"; (*c*) "Surgical Tuberculosis in South Africa and Its Treatment"; (*d*) "Chronic Diarrhea: Its Etiology, Pathology and Treatment, with Especial Reference to South African Conditions"; (*e*) "The Treatment of Industrial Surgical Accidents, with Special Reference to Restoration of Functions and Minimizing Subsequent Incapacity." The first prize will be 100 guineas, the second 60 guineas, the third 40 guineas. Full-time employees of the department of public health or full-time workers in research institutions shall not be eligible for the awards. The directors hope to be able to offer similar prizes from year to year. They will be known as the Maynard Prize Essays to commemorate their association with the late Dr. Maynard, who, as editor of the journal, was instrumental in establishing them. The Hamilton Gold Medal will also be awarded annually for the best paper published in the *Medical Journal of South Africa* in each calendar year by a bona fide resident of South Africa, but the award shall not be made a second time to the same person within a period of five years.

CORRECTIONS

Minutes of the Section on Laryngology.—In THE JOURNAL, June 21, under the minutes of the Section on Laryngology, it was stated that Dr. M. M. Stapler, Macon, Ga., presented an instrument which breaks up adhesions on the larynx. The word "larynx" should have been "labyrinth."

The Massachusetts Board.—In THE JOURNAL, March 22, p. 979, was an item referring to the Massachusetts Board of Registration in Medicine. It was based on a newspaper item which stated that a bill had been submitted to the Massachusetts legislature to abolish the board, that this bill was backed by the Massachusetts Medical Society and that the "only opposition to the bill" was from "persons connected with two grade C medical schools of the state." A letter from the chairman of the Board of Registration in Medicine states that, instead of supporting the bill, the president of the Massachusetts Medical Society opposed it before the legislative committee, and that representatives of the Class C schools supported the bill because they misinterpreted it to give the board power to refuse to examine their graduates.

Foreign Letters

LONDON

(From Our Regular Correspondent)

June 2, 1924.

Proposed Abolition of the Indian Medical Service

As foreshadowed in previous letters, the Indian Medical Service, which has played such an important part not only in the introduction of European civilization into India but also in the development of tropical medicine, is likely to be abolished. This seems to be an inevitable result of the granting of a large measure of self-government to India and the consequent Indianization of the government services.

Established in the first instance as a military service for duty with the Indian army, the Indian Medical Service has played a notable part in the civil life of India. It has not only devoted itself to the medical care of the civil population of both races; it has also been the chief agent in spreading throughout India, by means of collegiate and hospital teaching and by personal example, western ideas of medicine, surgery and sanitation, while among those who have devoted themselves to original research are some whose names are held in honor throughout the world. It has been increasingly evident, however, for some years past that some readjustment was desirable in the constitution of the medical service in India. A royal commission appointed to consider the possibility of transferring the superior civil services in India to services constituted on a provincial basis has presented its report. It recommends that a new civil medical service be constituted in each province, and recruited by competitive examinations held both in England and in India, the medical need of both the British and Indian armies in India being met, in future, by the Royal Army Medical Corps (India); that is, the medical corps of the British troops stationed in India. Every officer of the new provincial civil medical services should be liable for service with the Royal Army Medical Corps (India) in the event of general mobilization. To meet the medical needs of British officers in the civil services stationed in India, and their families, a minimal number of British officers should be maintained in the proposed civil medical service. Subject to the existing rights of present members of the Indian Medical Service, all scientific chairs in government colleges and hospitals should, in future, be thrown open to all candidates, the clinical chairs being reserved for members of the civil medical services, however recruited, so long as fit candidates are available. The commission considers that the almost universally expressed anxiety of British members of the services in India to have access to British medical advice for themselves and their families is vital to contentment. Owing to the geographic conditions of India, and in view of the increasing Indianization of the services, including the medical, the adequate provision of British physicians for the British members of the services presents peculiar difficulties.

The commission recommends that the districts of a province should be grouped, and a British medical officer (civil or military) should always be posted to one station in each group. This station should be within easy reach of each district in the group. In stations where there is no British medical officer, traveling allowances for the officer or his family should be granted to and from the nearest station where there is such medical officer. Payment should be made on a certificate by the medical officer, countersigned, if desirable, by the head of the medical service in the province. Alternatively, if more convenient or if the patient is not able to travel, the expenses of the medical officer's visit (exclusive of his normal fee for attendance) should be defrayed by the government. In the event of a case being of such a serious or special nature that the physician first consulted does not feel competent or willing to treat it, he may give a certificate authorizing the patient to travel to the nearest station at which adequate treatment can be given. This certificate should qualify the patient for the grant of traveling allowance. In stations at which only military medical officers are available, their services should be at the disposal of civil officers and their families, on payment of normal fees.

Epidemic Encephalitis

Last week, 251 fresh cases of epidemic (lethargic) encephalitis were notified in England and Wales, a slight decline from the week before. But this is incomparably the most extensive outbreak of the disease that has so far been recorded. The ministry of health has issued a further report, the most important feature of which is the attention devoted to the consequences of this strange disease, which may prove to be of great medicolegal importance. The sequelae are of both neurologic and medicolegal importance. They may appear: (1) in the course of the original acute malady and persist after partial or complete disappearance of all other symptoms; or (2) after the original acute attack has apparently terminated or possibly has passed unrecognized. Such effects are declared after a variable latent period, ranging from some weeks to over two years. No definite opinion, therefore, can be expressed until after some years as to whether an attack of acute encephalitis, however mild in appearance, may or may not result in serious sequelae. The most important after-effect is the mental condition that may supervene and may include irritability, maniacal outbursts and complete change in moral character and self-control. Lying and theft may appear for the first time in the conduct of the victim, as well as grosser mental defects (including even homicidal attacks), which may result in the patient's transference to a mental institution. These symptoms are of all grades of severity, and may be associated with nervous lesions. They are usually seen in children or in young adults. Thus, it is possible that some instances of motiveless crime and of violent behavior are the result of this disease, and not, as might be supposed, of inherent vice. Also other consequences of a physical type are described, and attention is directed to the fact that very mild cases of the disease occur. These may give rise to serious after-effects. The mortality in the present epidemic has been relatively low (from 12 to 20 per cent.). Specimens of cerebrospinal fluid from cases or suspected cases of epidemic encephalitis can be sent by physicians to the ministry of health for examination. Health officers are invited to take any action they consider useful and practicable to secure postmortem and pathologic examinations by skilled workers who are investigating the disease. In view of the severity of the disease and the importance of good nursing, hospital treatment is recommended. The isolation hospitals of local authorities should be available for this purpose. Any public nursing arrangements possessed by or arranged with the authority should be made available for cases treated at home. The other occupants of a house in which a case of encephalitis has occurred or is being treated are assured that the disease is one of low infectivity, and that very slight risk is run by association with the patient. At the same time, such association should be limited to what is necessary for proper care and nursing, and the patient should be well isolated in a separate room. School children in the affected household may be kept from school, as a precautionary measure, for three weeks after the isolation of the patient. Those in contact with the patient, however, may be advised to use antiseptic nasal sprays or douches and to gargle the throat with solutions such as those advised for influenza. For example, (1) 1 per cent. solution of hydrogen peroxid; (2) a solution of potassium permanganate, 1:5,000,

in 0.8 per cent. solution of sodium chlorid; or (3) solution of chlorinated soda, 0.5 per cent. These solutions can be used as ordinary throat gargles or snuffed up the nostrils, or applied by an efficient spray. Any persons in the infected household who suffer from sore throat or other symptoms suggesting an abortive attack are to be treated from this point of view and isolated as far as possible until they have recovered.

The British Medical Association

Dr. Alfred Cox, medical secretary, and Sir Jenner Verrall have gone to Canada on a visit to the Canadian Medical Association, at the invitation of the latter body. The membership of the British Medical Association at home and abroad has made progress during the past year and reached a record total. In England there was an increase of 872 members; in Scotland, 298; in Wales and Monmouthshire, forty-nine, and in Ireland, 108. In Asia the membership is larger by sixty-six, in Africa by forty-two, in North and South America by eighteen. In Australasia there was a gain of 262 members.

An Irish Problem

The establishment of the Irish Free State as an almost independent country has had some consequences not foreseen or desired by its advocates. An example is furnished by the address of the president, Sir Donald MacAlister. He said that unless the government of the Irish Free State should formally communicate to his majesty's government its desire for the continuance of the existing system, references direct or indirect to "Ireland" in the medical and dentists' acts must henceforth be read as references to "northern Ireland" only. In other words, the direct relations and responsibilities of "the General Council of Medical Education and Registration of the United Kingdom" will in future be restricted to Great Britain and northern Ireland. The universities and medical corporations and the physicians of southern Ireland will no longer be entitled to representation on the council. The medical qualifications granted by licensing bodies in the Irish Free State will no longer be placed on the British Register. The importance of this lies in the fact that a large proportion of the physicians who qualify in Ireland do not settle there but in other parts of the British Empire. Many of them go to England or enter the British army. Failing some new arrangement, these outlets will be closed to them. Some of these results cannot but be disadvantageous, not only to the public health, but also to medical education and to the medical profession in southern Ireland. A temporary continuance of existing conditions, pending the enactment of local legislation in southern Ireland, seems to afford at least an interim solution of the difficulty. The number of new physicians registered in 1923 was the highest on record—namely, 2,482—including 244 in colonial and foreign lists. In 1918, the number of students registered was 2,253; in 1919, the number rose to 3,420.

Factory Medical Inspection

The committee appointed by the government to inquire into the provisions of the factory and workshops acts for the medical examination of young persons as to their fitness for employment in factories has just issued an important report. The committee is much impressed by the highly organized system of medical examination and treatment of school children, and by the complete records kept by the local authority of the health conditions of every child leaving the elementary schools, and by the fact that in nearly every case the medical examination of the same children entering the factory is conducted by "the certifying surgeon" without reference to the previous health record, which has been up to that time carefully kept. For the resulting waste and loss, no blame is attached either to the certifying surgeon or the school medical officer, as no organization exists for their cooperation. The school medical service is not the only public health service in regard to which there is a lack of coordination. The certifying surgeon's work and that of the tuberculosis officer are carried on in water-tight compartments, and the action of the former in some cases has been inadvertently in direct opposition to the objects of the latter. Several witnesses who gave evidence before the committee stated that, from their experience, the examination of girls for such work was best and most suitably conducted by a woman, and the committee recommends that the examining surgeons should include women. Among many recommendations for the improvement of the system of inspection are that the age of children at examination should be raised from 16 to 18, and that the examination should be required in all factories and workshops, except such as the home office may, by special order, exempt.

Latin No Longer Compulsory for the M.R.C.P.

In this country there has existed for some years a tendency to displace the classical languages from the important position they once occupied in education. The latest example is supplied by the Royal College of Physicians, whose by-laws prescribed that a candidate for the M.R.C.P. shall satisfy the censor's board as to his education in science and literature. This has heretofore been taken to mean a working knowledge of Latin, and it has been optional for candidates to submit for examination in Greek, French or German also. At a recent meeting of the college, it was resolved that in future languages would not be compulsory, but that credit would be given to those who showed a knowledge in these subjects.

BELGIUM

(From Our Regular Correspondent)

May 23, 1924

Results of Radiotherapy

In a previous letter, I referred to the course of lectures delivered by Professor Regaud of Paris at the University of Liége on the subject of the radiologic treatment of cancer. It may be of interest to give a brief summary of the results of this treatment as reported by this specialist. The statistics cover the years 1919, 1920 and 1921.

SKIN CANCERS

During the three years 1919-1921, sixty-one epidermoids and seventy-four nonepidermoids were treated. Sixty-two per cent. of the epidermoids were apparently cured (95 per cent. of the operable and 40 per cent. of nonoperable cases). Of the nonepidermoids, 59.4 per cent. were apparently cured, or a slightly lower percentage than of the epidermoids. This is due mainly to the fact that in the case of many patients a cancer had received previously fractions of a full lethal dose of roentgen rays. In this connection, the following statistics are particularly instructive: Of cancer patients who had received previously one roentgen-ray treatment, 86 per cent. recovered. Of those who had received previously two roentgen-ray treatments, 54 per cent. recovered; three roentgen-ray treatments, 38 per cent.; four roentgen-ray treatments, 0 per cent. It may be easily seen from these experiences how important it is to succeed at the first sitting; for, when a cancer receives only a fraction of a lethal dose, the inevitable consequence is that the patient loses valuable time during which the tumor, unchecked, may grow in volume and in surface area; furthermore, the radiosensitiveness of the tumor may be decreased by insufficient doses.

CANCER OF THE MOUTH

The results secured in 1920 and 1921 are more encouraging than those of 1919. A report of the cases follows: (1) intralingual cancers: thirty-six cases, in which nine were benefited;

(2) dorso-anterior and latero-anterior cancers: fifty-two cases, in which thirty-one were improved; (3) dorso-posterior cancers: twenty-five cases, with five improved.

As to the length of time that patients survived the treatment, of the patients treated in 1919, only 5 per cent. were living a year afterward; of those treated in 1920, 29 per cent. were living a year later, while of the patients who accepted treatment in 1921, 58 per cent. had survived at the end of the first year. As to the relative success attained from the standpoint of the state of operability at the time treatment was given, an improvement was effected in 7.6 per cent. of the inoperable cases; in 33 per cent. of the cases that might be regarded as barely operable, and in 45 per cent. of the cases that were frankly operable.

CANCER OF THE UTERUS

In a series of 205 cases, 114 were not operable; in this group, 26.2 per cent. of apparent recoveries were recorded; in sixty-seven cases that had reached the limit of operability, there were 35.8 per cent. improved, while in twenty-four operable cases there were 45.8 per cent. benefited. In another series of twenty-six cases, 23.4 per cent. had no trace of cancer at the end of 1922. Beginning with 1922, Regaud and his adherents have introduced many notable improvements in their technical methods, and they have observed since that date a gradual betterment in their percentages of recoveries. However, they cannot be sure as yet that the progress is fixed and established, for the reason that the improvement has, after all, been only slight. At present, they use a combination of three methods of treatment, following this schematic formula: (1) roentgenotherapy for the purpose of sterilizing the more remote surrounding tissues; (2) local radium therapy, and (3) hysterectomy after retrocession of the lesions.

Health Insurance

The lower branch of the legislature has before it at present a bill pertaining to a compulsory form of health insurance. The proposed law will apply to workers of both sexes who are employed at a given wage or salary by the head of an industrial enterprise or by any other employer, provided they are earning less than 10,000 francs a year. Health insurance will be organized by the mutual companies for their own individual members and by the regional establishments for those who have not been admitted to the mutual companies. There will be a regional establishment for each arrondissement or district. Sickness benefits will be granted and paid by these primary organizations for a period of six months. In addition to compensation for a short (six months) period of illness and that for permanent total disability, the law provides also for indemnification for prolonged illness, which risk will be assumed, for a period of three years, by the federal mutual health insurance societies or by the regional establishments. The third category is disablement insurance. Any one who is no longer able to earn half of his normal salary is regarded as a partial invalid. The insured may lay claim to invalidity benefits when he has exhausted his rights in the primary and secondary organizations; that is, after the six months and the three years have elapsed. The primary mutual companies and the regional establishments guarantee their members free medical treatment and free drugs in addition to cash benefits.

The Treasury and Physicians

Since the legislation was enacted that provided for an income tax and a stamp tax on receipts, the treasury administration has been constantly introducing new methods of controlling the declarations of taxpayers. Until recently, the liberal professions and, more particularly, the medical profession, had escaped a rigid application of the law. But the minister of finance has now declared that a receipt must be given for all money received in the form of fees. The receipt blank must be taken from a receipt book with stubs or counterfoils, the type of which is to be determined by the minister of finance. All that is required to be written on the stubs or counterfoils is the amount of the fees, commissions or remunerations, together with the name of the debtor. Any person who pays an account without demanding a receipt is subject to a fine, being held coresponsible with the recipient of the amount.

State Provision of Antivenereal Drugs

Good results have been secured through government aid in the control of syphilis, but gonorrheal infection has not been suppressed to the same extent. Hoping for better progress in combating gonorrhea, the minister of the interior has decided not only to distribute gratuitously antigonorrheal vaccines but to institute also government control of their manufacture. Only certain physicians and institutions accepted for the treatment of venereal diseases may prescribe, at state expense, government controlled antigonorrheal vaccines.

The method adopted for the control of vaccines is as follows: When a manufacturer has prepared a stock of vaccine intended for general medical use, he sends a request to the public Health service that the lot be examined. A representative from the laboratory of the public health service inspects the stock, and takes with him from 2 to 5 per cent. of the stock as samples. If the result of the laboratory test is satisfactory, the administration notifies the manufacturer that the vaccine may be furnished to the pharmacists and physicians authorized to carry it. If the test results unfavorably, the whole lot is held back until its final disposition can be decided on.

The Belgian Society of Dermatology and Syphilology

The Société belge de dermatologie et de syphiligraphie has published the first number of its bulletin appearing since the war. It comprises more than 200 pages and contains reports of proceedings for the period from 1919 to 1922. The next bulletin (reports for 1923) will appear shortly. It is planned to issue then a bulletin every three months.

The Antisyphilitic Dispensary at the Maternity Hospital in Antwerp

At the instance of Dr. Henrotay, an antisyphilitic dispensary has been established at the Maternity Hospital in Antwerp. Henrotay has just published an account of his experiences in the dispensary since it was established, Nov. 1, 1922—for this is the first service of this kind to be organized in Belgium. Only women are treated in whom syphilis is discovered during their sojourn in the hospital in connection with their confinement. The women concerned are always informed of their condition, and are urged to report regularly at the dispensary at the same time that they take part in the consultations for expectant mothers. Contrary to the practice in Paris, the husbands of the women are not accepted for treatment, not only to prevent any possible promiscuity but also to avoid difficulties of an administrative character. The husbands are, however, frequently referred to a special dispensary. The statistics cover 128 cases (108 women and twenty children) who were registered at the special dispensary. Of the 108 women, forty-nine visited the dispensary regularly, forty-five irregularly. These results are encouraging. By educating the general public, and by intensifying the antivenereal campaign and the dissemination of the principles of hygiene, the crusade against infant mortality will become, from year to year, more and more successful.

Tuberculosis on the Belgian Congo

At the congress of tropical medicine held at Saint-Paul de Loanda (western Africa), Dr. Rodhain gave a report on the incidence of tuberculosis in various parts of the Belgian Congo as determined by means of the cutireaction. In Irebu Camp, of 1,200 cutireactions, 5.77 per cent. were positive in men, 2.57 per cent. in women, and 2 per cent. in children. At

Kinshasa he secured 16 per cent. of positive reactions in children. At Boma, 54 per cent. of the pupils of a school reacted positively. He gave comparative statistical figures for the years 1913 and 1923, which showed that the proportion of persons infected in the large centers had increased fourfold in ten years. The following measures have been adopted to check the march of the disease: compulsory notification of tuberculosis, refusal of admittance to the colony to Europeans presenting open lesions, the creation of sanatoriums for tuberculous natives: one at Banana, another in the neighborhood of Stanleypool, and others in various sections of the country.

PRAGUE

(From Our Regular Correspondent)

May 1, 1924.

Prevention of Cancer

The Society for the Study and Eradication of Cancer in Prague has decided to create an elaborate organization. Up to the present, the activities of the society have been largely theoretical, but it has accepted now the scheme proposed by Prof. Jaroslav Hlava, the senior of the medical faculty of the Prague University and the president of the society. An institute for research in cancer has been created in the new building for pathologic anatomy of which Professor Hlava is the director, an institute for the treatment of cancer has been organized by Prof. J. Jedlicka in the Podol Sanatorium, and a separate division for educating the public on the importance of cancer and methods for its prevention is being created. The society has accumulated considerable funds through the popularity of its president, and it has been given official recognition by a large gift of the president of the Czechoslovak Republic, T. G. Masaryk. The society feels that the Czechoslovak Republic is in an especially advantageous situation with regard to the treatment of cancer. The country contains large radium resources and therefore wants to organize an extensive cancer campaign along both preventive and curative lines.

A New Central Building for Medical Organizations

For a long time the medical profession in Prague has felt the need of bringing various medical organizations together in one center. A committee was appointed for the erection of a building for that purpose, and a site situated amid the buildings of the medical faculty was purchased. Activities were almost discontinued at the outbreak of the World War, but recently the committee has been reorganized and now is working hard to complete the project. The new building will bring together institutions that are widely scattered about the city. It is planned to transfer to this building the Union of Czechoslovak Physicians, the Society of Czech Physicians, which is an organization for postgraduate training, and the Library of Czech Physicians, which is a very old institution recently reorganized with assistance from the state treasury. It is also planned to house in the new building the Association of Czech Medical Students, which has always occupied an important position in the Czechoslovak medical profession, and which also owns a good library.

Professor Weigner's Fiftieth Birthday

Prof. Charles Weigner of Prague recently celebrated his fiftieth birthday. In spite of his age, Professor Weigner has achieved an important position on the staff of the Czech Medical Faculty in Prague. His early studies concerned the comparative anatomy of the cranial nerves and the structure and weight of the central nervous system. Following studies on the origin of man, his interest turned chiefly to problems of topographic anatomy, and only recently he completed a voluminous textbook on that subject. Together with Prof. L. Syllaba, he published a series of papers on the anatomic foundation for percussion. Professor Weigner is undoubtedly one of the best teachers of the Czech Prague Medical Faculty. His purpose has always been to teach anatomy in such a way that it would be of use in the practice of medicine and not simply as a science in itself. He has remained, therefore, in contact with clinicians, and his textbook is followed by medical practitioners. Besides his scientific activities, he is a leader in the physical culture movement. It is largely to his credit that physical education in the Sokol Unions has been put on a scientific foundation and that a School for Physical Education is now being built in Prague. He is one of the few medical men who has also considerable political influence.

A Course in Balneology

The Young Generation of Czechoslovak Physicians organized in April a course in balneology in cooperation with the Czech Medical Faculty in Prague. The course was given to stimulate interest in balneology in Czechoslovakia, which has such an abundance of thermal springs and watering places. Instruction was given on the treatment of heart diseases by carbon dioxid baths, the thermal treatment of bone diseases, balneotherapy in the home, physiotherapy, diathermy, and the climatic treatment of tuberculosis. The Czechoslovak Republic contains many watering places which are as effective as such famous watering places as Carlsbad and Marienbad.

Growth of Society for Combating Venereal Diseases

A committee of the Czechoslovak Society for Combating Venereal Diseases for the province of Moravia has been organized in Olomouc. Thus, Olomouc assumes the leadership in this work in that province, largely through the activities of Dr. V. Odstrcil, who is in charge of the dermatologic and venerologic department at the Olomouc general hospital, and associate professor of venerology at the Prague Medical School. The extension of activities to Moravia is proof of the growth of the society, which was largely responsible for the abolitionist legislation in the Czechoslovak Republic. Immediately before and after the passage of this law, the society had to stand may attacks from the reglementarists, but in operation the law has brought a full justification of the stand of the society which is shown now in the increasing popularity of its ideas.

HOLLAND

(From Our Regular Correspondent)

May 6, 1924.

Automobile Insurance for Physicians

The cost of automobile accident insurance has increased considerably. Many insurance companies have added 25 per cent. to the premiums on policies of physicians, on the ground that they are exposed to greater risks, since they drive in all kinds of weather and at night. Statistics seem to show, however, that accidents occur much less frequently among physicians than among inexperienced drivers. In order properly to adjust the insurance premiums, many medical societies have requested insurance companies to consider the organization of a mutual automobile accident insurance company for physicians.

Bovine Tuberculosis and Rabies in the Dutch East Indies

A report published by the veterinary service of the Dutch East Indies for 1922 contains interesting information regarding tuberculosis and rabies. It appears that bovine tuberculosis is still widespread, although a progressive improvement is noticeable. At Soerabaja there is a government station to which several veterinarians are attached whose duty it is to detect disease in animals. They not only use the tuberculin test but also resort to injections into guinea-pigs in addition to clinical diagnosis. Such an organization

requires a large personnel, and so far it has not been feasible to extend this service to the whole country.

In 1922, 113 cases of rabies were observed as against seventy in 1921. Here again the crusade against infection is rendered very difficult by a lack of funds. Observations in the interior of the country have not been provided for, and it must be admitted that the system is not effective except in large towns.

Deafness in School Children

At a recent meeting of school physicians, Professor Burger presented a communication on the relation of adenoids to deafness in school children. In a previous letter, I mentioned the organization of schools for backward children. It is interesting to note the distinctions that Professor Burger makes. After separating the deaf-mutes from the group of children in whom defective hearing causes an impairment of education, he holds that not all children who have a certain degree of deafness should be assigned to special classes for deaf children. In other words, it is not the degree of organic deafness that should determine whether a child should attend a special school. Many children with reduced hearing are able to pursue the ordinary courses, and for them to remain in the usual classes is a privilege which they should not be denied. In classifying children, therefore, a careful selection should be made without following any absolute rule, and each case should be dealt with individually. Deafness itself should not be the sole criterion, but the question, Is the child able to keep up with his classmates? It is especially important that children with defective hearing shall not be in contact with deaf-mutes.

Law Regarding Infectious Diseases

A bill pending in the lower branch of the legislature has given rise to much controversy. The question at issue is vaccination against smallpox. Vaccination is not compulsory for everybody, but in spite of the objection of the medical societies, a paragraph was introduced in this bill to exempt those who have religious or philosophical scruples against it. It is evident that this opens the way for all sorts of objections, and that a person who wishes to escape would only need to state that he is opposed to vaccination. The law therefore would be a menace to public health.

The Nederlandsch Congres voor Openbare Gezondheidsregeling called a meeting to discuss the proposed law. The speakers emphasized the danger of such exemption, and demanded that the bill be modified so as to exempt from vaccination only those whose health would be impaired by it. To prevent the abuse of this reservation, the opinion of one physician should not be sufficient to secure exemption, but the written statement of two physicians whose authority is acceptable should be required. This, at least, was the opinion of Dr. Kuiper.

In some regions the opposition to vaccination seems widespread. Figures presented at this meeting by Dr. Folmer of the province of Zuid-Beveland indicate that among the 50,000 inhabitants nearly 15,000 oppose vaccination, and in some communes about 50 per cent. of the population oppose it. These figures, however, reflect the sentiment in a small part of the country. Following the special meeting of the congress, the sanitary commission of Velsen passed a resolution calling attention to the menace to the whole population that a small minority of antivaccinationists might be. It proposed that a petition be sent to the lower house demanding a revision of the bill.

Dr. Heynsius van den Berg, director of the association for combating tuberculosis, has published a report on the favorable situation in Amsterdam which resulted from introducing hygienic measures and from the improvement in the food situation since the war closed.

Of the new cases of tuberculosis that came to the attention of the consultation bureaus in 1922, 44 per cent. developed in the family of a tuberculous person. The results of the Pirquet test during the period 1919-1922 showed that the belief that tuberculous infection after the age of 15 is universal in large cities is not true of Amsterdam, where the percentage of positive reactions after this age was 80.8.

While the center of Amsterdam has the aspect of a metropolis, the highest mortality from tuberculosis is not found in the center of the city but in the more remote sections. In spite of improvement in the housing situation, there were still many families at the close of 1922 that were confined to one room.

BUCHAREST

(From Our Regular Correspondent)

May 21, 1924.

The Spread of Venereal Diseases Among Boys

According to the statistics of the venereal clinics, compiled by the board of health, a great percentage of venereal patients is recruited from the students of the secondary schools. The matter is the more serious, as most of them, according to the medical reports, get to the clinics when their disease is so far advanced as to render their sure and quick healing almost impossible. The school authorities conferred with hygienists, and agreed that the excessive spread of venereal disease, which has occurred also in several other countries, is an aftermath of the war. They agreed that vice does not originate from individuals, but from the age period. It was their belief that the introduction of weekly medical examinations in the upper school classes, as among the military, would lead to early discovery of the diseases, insuring better results in treatment. The examinations should be performed by medical men and not by teachers, as formerly. Precautions should be taken lest students hide. It has been noted that healthy children presented themselves, but the sick ones stay away, fearing that their parents will be made aware of their condition. It was advised that the subject of venereal diseases be taught in the higher classes, with means of protection. It would be left to the discretion of the teacher to avoid offending the modesty of the students. Children should be examined singly, and in case of venereal disease the source should be ascertained, that the infected person might be treated in a suitable hospital.

The Ravages of a Mad Wolf

In a village near Turda, a large wolf from the mountains bit several dogs and some people on the night of March 15. The beast was finally killed, though the village was in an annexed district, where the keeping of arms is prohibited. Examination disclosed that the wolf had rabies. All bitten persons were sent to the Pasteur institute at Cluj. After the completion of treatment and having returned home, four, who had had very severe wounds on the head or on the back, near the vertebral column, again presented symptoms of rabies. One ran into the forest, where he was found dead.

Drawbacks of Centralization in Workman's Insurance Offices

Transylvania, now a possession of Roumania, had an efficacious workmen's insurance system before the war, copied from the German and English systems. The workmen had an excellent medical service with free medical choice, and any kind of medical or surgical treatment was available. Roumania, however, suspended the system of autonomy and introduced central management. This system has led to great dissatisfaction. In the case of urgent need for an expensive artificial limb, for example, this could be given only after the preliminary approval of the Bucharest central office, which worked very slowly. The postal service is still slower. The

government refused to restore autonomy, but made some consessions. The result is that a once excellent institution is deteriorating. For instance, the government issued an order a year and a half ago that the pharmacies of the workmen insurance ambulances be closed and the sick people allowed to choose any pharmacy they wished. The order aroused general rejoicing among workmen, because, apart from the fact that these district pharmacies do not contain suitable medicines, it was a great bother for the sick to go to the insurance pharmacy which is open only at certain hours. But before the order came into force, it was withdrawn. The patients also are not satisfied with the physicians. The insurance fees paid by members are high, and the physicians get very low salaries, so that many good practitioners have withdrawn from the clubs. The consequence is that many club members would rather go to private physicians than be attended by the insurance physicians.

This is the situation in the cities. In the provinces it is still worse. Patients sent to villages for change of air are complaining of hunger. Medical attendance is deficient; in fact, the activity of the insurance is nothing but the collecting of fees and the bookkeeping. Sickness support is not paid regularly, and sometimes weeks pass before a disabled man gets the pension that is due on the first of the month. There are places, for instance, Vilinga, where there are more than 2,000 forest workmen, and no insurance physician at all. The salary is so small that nobody cares for the position. There are other complaints, too, with regard to certifying a man's disability after an accident. When the insurance offices had autonomy, they did this themselves, such an office having been in every large town. Since centralization was imposed, every case has to be certified in Bucharest. As some applicants would have to travel distances requiring a trip of from twenty-six to thirty hours, with the attendant high fare, it is easy to believe that some of the disabled would forego their pension rather than make the long journey.

All these complaints have been placed before the minister of public welfare in a memorandum. He has directed a member of the supreme sanitary council to draft a new bill, on a more enlightened basis. He will place the bill before parliament as soon as possible, and he informed the press that the present conditions will not last long.

A Curious Case of Alleged Professional Indiscretion

In a large city of Roumania, a married man who had gonorrhea was treated by a specialist. Owing to frequent interruption, the treatment lasted more than three months, without the disease being healed. The patient tried another specialist without having settled the bill of his former medical attendant. The physician waited six weeks, although it is the custom, approved by the Roumanian Medical Association, to present bills immediately after the termination of a case, and if a long treatment is in prospect, that the physician shall receive an advance covering about half the amount in prospect. The physician in question sent a bill to the patient; unluckily, it was received by the wife, who reproached her husband, and the matter ended in a divorce. The husband sued the physician for damages, accusing him of professional indiscretion, on the ground that a venereologist ought not to use bill heads displaying his specialty, particularly if he sends the bill to a married man. The physician replied that the patient knew he had to pay for the treatment, the more so as the physician met the patient on the street and told him that it was not nice to interrupt the treatment without having settled the bill first. The patient asked the amount he owed, and promised to send it the same day. This he did not do, and the physician waited six weeks, which was plenty of time. The patient should have foreseen that a bill would be sent to him. The designation of venereologist on the bill, he asserted, was discreet enough, as its meaning is not known to 990 out of 1,000 women. A man with a wife so highly educated as to know this word ought to have been cautious enough to avoid the possibility of the bill's being sent. The patient protested that the city was not so large that everybody in it did not know who the venereologists were, and that even if his billhead did not contain the appellation, his wife would have known. The court accepted the defense of the physician, and ordered that the patient pay his debt in eight days, together with the legal costs of the case.

Position of Pharmacists in the Annexed Parts of Roumania

In the annexed parts of Roumania, particularly in Transylvania (with a population of about four million), recently a part of Hungary, a pharmacy could be opened only with the permission and approval of the ministry of health, on the ground that a pharmacist needs a long period of study before beginning practice, and the great responsibility demands that he shall be discriminated from a merchant or a druggist. The ministry has granted licenses on the basis of one pharmacy for every 4,000 or 5,000 inhabitants in towns, thus insuring their prosperity. The licenses have been of two kinds: with real rights and with personal rights. The former were granted in older times, and meant that the pharmacy could be owned by any one to whom the original license holder or his successor sold it, the sanitary law demanding only that the pharmacy be managed by a duly qualified man, with qualified assistants. A license with personal rights differs from this only in that it can be owned only by a duly qualified pharmacist. Naturally enough both represented a fairly high value because, in case the owner died, the pharmacy could be sold for a considerable sum, insuring a livelihood for the owner's family. Since Transylvania came under Roumanian law, conditions have changed, as the Roumanian law does not license pharmacies, pharmacy being free, as in France, where a pharmacist may open a pharmacy wherever he likes. This, of course, lessens the value of the pharmacies that were bought from a license holder, sometimes at a high price, because now any pharmacist may open a pharmacy next door. The Roumanian laws prescribe that the pharmacies that were held by personal right licenses are not transferable after the death of the owner, but are under the disposition of the state. About 900 families are affected by this, and an attempt is being made to avoid the application of the law. This attempt will probably succeed, as the Roumanian government has guaranteed the preservation of the Hungarian sanitary system and laws for a transitional period of ten years.

Physicians in the Chamber of Deputies

Sanitation and the affairs of the medical profession are step children of legislation. This was the conclusion reached at a recent meeting of the Oradea Mare branch of the medical association. Rooms in physicians' dwellings are being requisitioned. Young practitioners are unable to get a dwelling on account of the great scarcity of substantial houses, while officials of the state get dwellings through requisition. Physicians are charged exorbitant taxes on their earnings, the rate being from 10 to 12 per cent. of the income. Physicians are charged the highest tariff for telephones, just as are merchants or banks, while a private party pays only one third. The statement was made that these things would not happen if the medical profession were represented in parliament. A resolution, therefore, was passed, calling on all branches of the medical association to choose medical candidates, and to support them at the approaching general elections. In Roumania there are many physicians in responsible offices, including several county prefects; it may be hoped, therefore, that the profession will succeed in electing ten or fifteen deputies.

Marriages

RAMSAY SPILLMAN, Washington, D. C., to Miss Margaret Eleanore Kimmel of Fort Hamilton, N. Y., May 12.

JAMES M. FADELEY, Washington, D. C., to Miss Marian Parker of Berryville, Va., at New York, May 2.

THEODORE W. KEMMERER, Washington, D. C., to Mabel Clare Williams, Ph.D., of Iowa City, June 4.

SIDNEY B. TRATTNER to Miss Leah Whitlock Binswanger, both of Richmond, Va., May 5.

PAUL E. SPANGLER, Boston, to Miss Clara Wise Raymond of Cambridge, N. Y., June 11.

JOSEPH CLEMENT MICHAEL to Miss Blanche MacCarthy, both of Minneapolis, May 17.

SOLOMON GILMORE PONTIUS to Miss Helen Hohman, both of Lancaster, Pa., April 5.

ROYAL STORRS HAYNES to Miss Pauletta Lacosta, both of New York, June 11.

THOMAS HULICK to Miss Augusta B. Reese, both of Cincinnati, June 5.

Deaths

James Bozeman Baird ● Atlanta, Ga.; Bellevue Hospital Medical College, New York, 1871; formerly professor of principles and practice of medicine at the Atlanta College of Physicians and Surgeons; past president of the Medical Association of Georgia; at one time member of the board of health, and state board of medical examiners; on the staff of the Grady Hospital; aged 75; died, June 6.

Charles Farmer ● Louisville, Ky.; Hospital College of Medicine, Medical Department Central University of Kentucky, Louisville, 1897; adjunct professor of abdominal surgery and gynecology at the University of Louisville Medical Department; past president of the Jefferson County Medical Society; veteran of the Spanish-American and World wars; aged 55; died, June 8.

Beverley Robinson, New York; University of Paris, France, 1872; emeritus clinical professor of medicine at the University and Bellevue Hospital Medical College and consulting physician to St. Luke's and the City hospitals; author of the "Treatment of Ordinary Diseases" and other works; died, of arteriosclerosis and chronic heart disease, June 21, aged 80.

Ambrose Burdett Crain ● Belton, Texas; Medical Department of the Tulane University of Louisiana, New Orleans, 1908; served in the M. C., U. S. Army, with the rank of captain, during the World War; for ten years county health officer; aged 40; died, June 3.

Charles W. Williamson, Poplar Bluff, Mo.; Beaumont Hospital Medical College, St. Louis, 1887; member of the Missouri State Medical Association; aged 62; died suddenly, June 3, at St. Louis, of heart disease.

James Murry Gallison ● Boston; Medical School of Harvard University, Boston, 1908; on the staff of the New England Deaconess Hospital; aged 45; died, June 14, of a skull fracture, received in a fall.

Henry H. Jones, Dunmore, W. Va.; University of Maryland School of Medicine, Baltimore, 1867; member of the Virginia State Medical Association; Civil War veteran; aged 84; died, May 11, at Mebane, N. C.

Joseph Albert Seligman, Baltimore; University of Maryland School of Medicine, Baltimore, 1892; member of the Medical and Chirurgical Faculty of Maryland; aged 58; died, June 13, of heart disease.

John Alexander MacCaskill, Barre, Vt.; University of Vermont College of Medicine, Burlington, 1920; member of the Vermont State Medical Society; aged 27; died, May 29, following a long illness.

Giovanni Merenna, Brooklyn; Medical Department of Columbia College, New York, 1893; member of the Medical Society of the State of New York; aged 61; died, June 4, following a long illness.

Henry Allen Halsey ● Wyoming, Ohio; Rush Medical College, Chicago, 1907; served in the M. C., U. S. Army, during the World War; aged 41; died, June 6, at the Jewish Hospital, Cincinnati.

John Andrew MacDonald, Montreal, Que., Canada; McGill University Faculty of Medicine, 1880; aged 67; died, May 8, at the Royal Victoria Hospital, following an operation for appendicitis.

Travis Raybourne Black, Clarksville, Texas; Memphis (Tenn.) Hospital Medical College, 1898; served in the M. C., U. S. Army, during the World War; aged 51; died, February 28.

Archibald Dixon, Henderson, Ky.; Louisville Medical College, 1877; member of the Kentucky State Medical Association; formerly county health officer; aged 80; died, June 9.

Adelaide Mary Tyrell ● Chicago; University of Illinois College of Medicine, Chicago, 1909; aged 62; died, June 5, at the Henrotin Hospital, of pneumonia, following an operation.

Charles James Maxwell, Hinsdale, Mass.; Baltimore (Md.) Medical College, 1909; member of the Massachusetts Medical Society; aged 39; died, June 4, following a long illness.

John B. Coakley, Buffalo; Medical College of Virginia, Richmond, 1861; member of the Medical Society of the State of New York; Confederate veteran; aged 85; died, June 4.

Charles Darwin Carpenter, Walton, Ind.; Medical College of Ohio, Cincinnati, 1872; member of the Indiana State Medical Association; aged 75; died recently, of heart disease.

Augustine Claiborne Somervill, Mason, Tenn.; University of Pennsylvania School of Medicine, Philadelphia, 1858; Civil War veteran; aged 88; died, May 17, of senility.

William Herbert Pepler, Toronto, Ont., Canada; Trinity Medical College, Toronto, 1885; L.R.C.P. and L.R.C.S., London, Eng., 1887; died suddenly, April 30.

Taylor J. Bingham, Philo, Ohio; Columbus Medical College, 1880; member of the Ohio State Medical Association; aged 76; died, May 25, of heart disease.

Parker Nathaniel Balcom, Aylesford, N. S., Canada; Medical Department of the University of the City of New York, 1875; aged 74; died, April 28.

Henry Stafford Whisman ● San Francisco; Johns Hopkins University Medical Department, Baltimore, 1915; aged 34; died, May 15, at San Jose.

John Emmett Walsh, Highland, Wis.; University of Illinois College of Medicine, Chicago, 1910; aged 42; died, May 27, of cerebral hemorrhage.

John A. Campbell, Oak Park, Ill.; Chicago Homeopathic Medical College, 1879; aged 69; died, June 15, of inanition and senile dementia.

William C. Cullom, Mesquite, Texas; University of Nashville (Tenn.) Medical Department, 1872; aged 71; died, April 23.

William Dominick Finn, Halifax, N. S., Canada; Medical Department of Columbia College, New York, 1890; died, April 13.

John A. Capp, Lancaster, Pa.; University of Pennsylvania School of Medicine, Philadelphia, 1878; aged 75; died recently.

Charles Edward Sugden, Winnipeg, Man., Canada; Chicago (Ill.) Homeopathic Medical College, 1894; aged 53; died, May 12.

D. S. Talbot, Appleton City, Mo.; Eclectic Medical Institute, Cincinnati, 1889; aged 77; died, April 16, of heart disease.

George Lamond Winn, Rockford, Ill.; Chicago Medical College, 1876; aged 73; died, June 9, at Two Rivers, Wis., of senility.

Brice Howard Elder, Peoria, Ill.; Indiana Medical College, Indianapolis, 1878; aged 75; died, June 15, following a long illness.

Miles H. Alderson, Salina, Kan.; University of Louisville (Ky.) Medical Department, Louisville, 1867; aged 82; died, June 5.

Peter M. Menefee, Eureka, Calif.; St. Louis (Mo.) Medical College, 1871; aged 82; died, May 2, of bronchopneumonia.

William Bradley Clarke, Pittsburgh; Chicago (Ill.) Homeopathic Medical College, 1884; aged 76; died, June 7.

Robert Thompson Stratton, Oakland, Calif.; Jefferson Medical College of Philadelphia, 1886; aged 62; died, May 5.

Francis P. McCormick, Seattle; University of Michigan Medical School, Ann Arbor, 1883; aged 64; died, June 1.

Georgia Sackett Ruggles, Los Angeles; Woman's Medical College of Chicago, 1883; aged 73; died, May 23.

Edwin Rodd ● Detroit; Detroit College of Medicine and Surgery, 1893; aged 62; died, June 3.

Correspondence

THE PRESCOTT COFFEE REPORT

To the Editor:—This is a criticism of Prof. Samuel C. Prescott's coffee report, which was presented to the "Joint Coffee Trade Publicity Committee" meeting in Boston, Oct. 17, 1923, and was later published.

Professor Prescott, after a three-year research at the Massachusetts Institute of Technology, at a cost to the coffee people of about $40,000, issued a report in which this statement appears on the first page: "It was understood from the start that this work should be conducted scientifically. . . . Whether the findings were pleasant or unpleasant, no scientific worker can afford to temporize with truth." Farther on he states that "in the dispassionate study of the vast literature on the subject, much of which was medical literature" he has come to the "conviction . . . that for the overwhelming majority of adults coffee is a safe and desirable beverage." This sentence has been enormously broadcast to the people of the United States.

Professor Prescott apparently took no notice of the harm that coffee can do, as certified to by Sollmann, by Hatcher, by Wood, by Cushny, by Hare, by me and by many others. It certainly was not "scientific" to omit entirely reference to some of these books, which so positively assert the harm that caffein can do to some persons in small amounts and to many persons in large amounts.

The few restrictions that Professor Prescott mentions in the body of his report were never listed in the advertisements issued by the "Coffee Publicity Committee," and as these advertisements were repeated for several months, apparently Professor Prescott did not object to the omission of his restrictions. Professor Prescott, and his $40,000 research, were made in these advertisements to declare scientifically (?) the harmlessness of coffee, and therefore caffein.

On page 21 of his report, he likens the action of caffein to the lubrication of machines, as increasing the mental and physical work of the individual. Priority must be given to Hare, who in the 1918 edition of his book on "Practical Therapeutics" states that caffein "acts as a lubricant does on machinery." He did not note Hare's statement on the next page of his book that "in certain persons the habitual use of coffee in excess in the presence of overwork and lack of sufficient rest and food may result in insomnia, tremors, palpitation, tinnitus aurium, gastralgia and emaciation," and that caffein has been known to cause delirium closely resembling that of alcoholism.

The simile of lubrication is, of course, a bad one, as a properly lubricated machine runs more smoothly and without friction, while a person who is stimulated by coffee runs at a higher speed, and, unless his mechanism is perfect, there will be increased friction and increased wear and tear on the nervous and circulatory systems.

Professor Prescott also states that coffee "does not draw on the physical reserve of the body." I know no authority for this statement. Coffee gives nothing to the body, but does draw on the physical reserves, as do all stimulants. Coffee is not a food, and, as Cushny states, "it has been shown conclusively that, far from lessening the metabolism of the body, coffee and tea increase it." Therefore, coffee is a promoter of waste and uses up reserves. It adds nothing to the body, but whips it up, like thrashing a tired horse, which is in need of rest and food. If a tired person continues this whipping process with coffee, he will soon find that many unpleasant symptoms develop, such as digestive disturbances, nervous irritability, heart irritability, and sleeplessness.

Professor Prescott states in this report that "caffein has no depressive after-effects, whereas all other stimulants have." He forgets that strychnin is in the same class; but the overuse of either caffein or strychnin can soon tire the system and cause unexpected overaction. He later states that caffein is not a "drug" or a "narcotic poison." Of course, this is a joke for the general public, as no medical man, no laboratory expert, and no chemist would ever term caffein a narcotic poison; and of course caffein *is* a drug, from the standpoint of its use for medicinal purposes. Prescott, of course, knows this, and doubtless used the phrase not a "drug" for the coffee advertisers to use as a catch phrase to the laity, showing that caffein is not in the dope class.

He also states that caffein is not habit forming in the sense that constantly increasing quantities are required. This is true, but almost every person who drinks his coffee regularly knows that he seriously misses it if he omits it from his diet.

In the report appear some restrictions, such as "Not all individuals have the same caffein tolerance," and some hypersensitive individuals should not drink it, and some have idiosyncrasy against it. None of these restrictions appeared in any of the coffee advertisements.

He also states that "the average cup of strong coffee contains from 1½ to 1¾ grains of caffein. This is ample in some individuals to give a quicker heart beat, hence increase the circulation and activates more pronounced mental processes. Other individuals may require two or four times as much to provide the same stimulation." Again he shows the drug activity of the caffein in coffee. He also found, experimenting on animals, that the condition of the animal had considerable to do with the activity of the caffein. This caution was not broadcast to the public.

He studied the literature on coffee in five different languages, he states, and apparently found no harm from coffee. Whether coffee was perfectly harmless in any amount for the people of other ages, of other nations, of other climates, of other races, can have no bearing on the amount of coffee that the people of the United States may drink with safety at the present era of nervous irritability.

Professor Prescott's $40,000 investigation did not discover what it is that renders the caffein in coffee less active than caffein administered as an alkaloid, which would have been very desirable knowledge to acquire.

The investigation also did not disclose the standing of the "caffetannic acid," which he simply accepts as a finding of many chemists.

In other words, this enormous and expensive investigation did not result in anything new in regard to coffee or caffein pharmacologically or therapeutically, but did result in an enormous propaganda to promote the increased sale and consumption of coffee, and this propaganda can do great harm to a large number of people of the United States, who cannot and should not drink coffee as a beverage.

OLIVER T. OSBORNE, M.D., New Haven, Conn.

Capillary Pulsation.—The capillary pulsation of aortic disease may appear in any part of the skin of the body under suitable conditions. Thus it can be induced almost anywhere by friction or the application of heat. Looking at the skin in cases of free aortic regurgitation as these come to an outpatient department, there are a few areas where capillary pulsation is usually distinctly visible without touching the skin; these are the forehead and cheeks. In some cases, not so uncommon as they are usually believed to be, the reddening of the face with each systole and its paling with each diastole are so distinct that they may be visible at a considerable distance from the patient. . . . I have seen a few instances in which the spontaneous flush was visible over the whole hand.—Lewis, T.: Studies of Capillary Pulsation, *Heart* **11**:151 (April) 1924.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

TOXICITY OF GASOLINE

To the Editor:—Are gasoline fumes or vapor toxic, and if so in what way do they manifest their toxic properties? We have a death certificate signed giving, as the cause of death, exposure to gasoline fumes. The exposure occurred on Monday, and the following Sunday the patient died. He is said to have had during these days attacks resembling angina pectoris.

R. H. DENHAM, M.D., Grand Rapids, Mich.

ANSWER.—Benzin (gasoline, naphtha) vapors are toxic. The effects of acute poisoning from inhaling moderate amounts of benzin resemble mild alcohol intoxication; in dry cleaning plants it is sometimes spoken of vernacularly as "naphtha jag." According to Alice Hamilton (Industrial Health, edited by George M. Kober and Emery Hayhurst, Philadelphia, P. Blakiston's Son and Company, 1923, p. 497), the complaint is usually of nervous symptoms, such as pricking and crawling sensations, headache, poor sleep, drowsiness, twitching muscles, coldness and numbness in fingers and toes; digestive symptoms; loss of appetite; indigestion; colic, and loss of weight. In still more serious cases, which are rare in proportion, Lewin (ibid.) states that there is a rapidly increasing weakness, quick and weak pulse, labored respiration, delirium and coma.

Cases of death due to vapors from benzin itself are exceedingly rare.

Sometimes the products of partial combustion of benzin are erroneously called "gasoline fumes," when in reality they contain carbon dioxid and the very toxic and frequently fatal gas carbon monoxid.

THERAPEUTIC LAMPS

To the Editor:—Will you kindly tell me what is the actual therapeutic value of the therapeutic lamp? How does it compare with the Kromayer lamp or the Alpine sun lamp? Are there advantages of one over the other? Any authoritative information, as well as reference to articles by competent men, will be appreciated.

JOHN Z. MRAZ, M.D., Oklahoma City.

To the Editor:—I notice you carry an ad of both burning and nonburning ultraviolet lamps. Which one gives the better therapeutic results?

J. A. BURNETT, M.D., Crum Creek, Okla.

To the Editor:—Will you kindly let me know your opinion on infra-red therapy and give me, if possible, a brief résumé.

KARL W. SMITH, M.D., Madison, Wis.

To the Editor:—A recent number of THE JOURNAL contained an ad of the "ultra sun lamp." Can you supply me with any information concerning this lamp? What I wish to know is whether this lamp is equal in therapeutic value to other ultraviolet ray lamps. The feature of this type is supposed to be "nonburning" when used over a long period; however, I wish to know the therapeutic value.

F. B. SCHROEDER, M.D., Princeton, Ill.

ANSWER.—The Kromayer water-cooled mercury-quartz light and the Burdick and Hanovia mercury-quartz lights are all considered sources of ultraviolet radiation of strong intensity, emitting a large quantity of long and short ultraviolet wave lengths. In contrast to this, carbon arc lamps, of which the ultra-sun lamp is an example, are used more particularly for the rays present similar to those in the spectrum of sunlight; namely, the invisible heat wave lengths, the visible rays and the longer ultraviolet rays. The nonburning feature of the ultra-sun lamp is due to the practical absence or very weak intensity of the short ultraviolet rays, which are the wave lengths that irritate and easily produce an erythema.

The advertisers of the ultra-sun lamp stress the fact that the spectrum of their lamps is a continuous one, whereas the spectrum of the mercury quartz lights has gaps. This is true. No one has yet proved, however, that the presence of gaps in a spectrum is a drawback in the clinical use of that light. Furthermore, no one has proved that the burning or erythema-producing rays of the mercury-quartz lights are disadvantages. It is possible that the erythema-producing rays are even valuable for clinical effects in various disease manifestations.

As to the therapeutic value of the carbon arc lamps, it cannot be said that these lamps are less valuable than the mercury-quartz lamps for certain diseases. There are special indications for different sources of light, but the exact indications have not yet been worked out. For superficial disease, such as superficial tuberculosis, it is probable that with proper application the shorter ultraviolet rays of the mercury-quartz lights can prove most helpful. For rickets and tetany, both sources of radiation have demonstrated their worth. For extrapulmonary tuberculosis, such as of bones and joints, intestines, peritoneum and lymph nodes, both sources of light have had strong adherents and have shown their value. The enthusiasts for solar treatment will insist that a spectrum closely approximating that of sunlight is necessary, and therefore they particularly advocate carbon arc lamps. Others, who have had favorable results with mercury-quartz lights, can give important evidence in their behalf and argue against the need of a spectrum similar to that of sunlight.

Some disadvantages of carbon arc lamps include the emission of sparks, formation of soot, added expense of running the lamp, and the need of longer durations of exposures.

The physician may decide for himself the advantages of purchasing one lamp over another, depending chiefly on the conditions to which he wishes to apply the method.

KETOGENIC-ANTIKETOGENIC RATIO

To the Editor:—Will you state in Queries and Minor Notes just what is meant by the term "ketogenic-antiketogenic ratio" as used in discussing diabetes? Also give accepted formulas.

H. H. B.

ANSWER.—By "ketogenic-antiketogenic ratio" is meant the proportion between substances that form glucose in the body and those that form fatty acids. The importance of this ratio lies in the fact that, both in normal and in diabetic metabolism, fat is oxidized only in a definite mathematical proportion to the amount of glucose oxidized. If extra fat is burned, the oxidation is incomplete, and "acidosis" occurs, first made manifest by the appearance of acetone in the urine. This will occur in normal persons if, for any reason, carbohydrate is withdrawn, or in diabetic patients when the capacity to burn carbohydrate is so diminished as to furnish insufficient amounts of oxidized glucose for the amount of fat. Thus, in the treatment of diabetes a mathematical ratio is necessary.

It is now generally accepted that glucose is derived not only from carbohydrate but also from protein and from the glycerol fraction of fat. Fatty acids (the precursors of acetone) are derived from fat and from protein. Woodyatt's formula based on these statements is:

$$\text{G (Glucose)} = \text{Carbohydrate} + 0.58\ \text{Protein} + 0.1\ \text{Fat}$$
$$\text{F. A. (Fatty acid)} = \text{Fat} + 0.46\ \text{Protein}$$

$$\frac{\text{F. A.}}{\text{G.}} = 1.5$$

Other formulas have been devised. Ladd and Palmer recommend a simpler method of calculation, which is based on previous work of Celler. The glucose (antiketogenic) fraction is carbohydrate + 0.58 protein; the ketogenic is just fat, and the proportion is

$$\frac{\text{F}}{\text{G}} = \frac{2.5 - 4}{1}$$

The amount will vary with individual patients.

VEHICLES FOR PRESCRIPTIONS

To the Editor:—Some years ago (when the American Medical Association held its annual session in Chicago last time), the department of pharmacy exhibited a quantity of elegant vehicles. These were, of course, official. The object, I remember, was to show the profession that there were plenty of elegant and refined vehicles without buying the special preparations from the manufacturing companies. I wish that I had that list, or perhaps you know of some publication dealing with the subject of pleasant preparations.

H. M. HICKS, M.D., Amsterdam, N. Y.

ANSWER.—The following is a list of the vehicles exhibited at the annual session of the American Medical Association in 1918:

Aqueous Elixir of Glycyrrhiza, N. F.
*Compound Elixir of Cardamom, N. F.
Compound Elixir of Almond, N. F.
Compound Elixir of Vanillin, N. F.
Glycerinated Elixir of Gentian, N. F.
*Elixir of Anise, N. F.
*Red Aromatic Elixir, N. F.
Compound Syrup of Asarum, N. F.

There were also exhibited Aromatic Syrup of Senna and Aromatic Syrup of Rhubarb, which, of course, are not mere vehicle preparations.

The formulas may be found in the Epitome of the Pharmacopeia of the United States and the National Formulary, published by the American Medical Association. Those with an asterisk may be prescribed only in according with the rules governing intoxicating liquors.

Medical Education, Registration and Hospital Service

COMING EXAMINATIONS

ALABAMA: Montgomery, July 8. Chairman, Dr. S. W. Welch, Montgomery.

CALIFORNIA: San Francisco, July 7-10. Sec., Dr. Charles B. Pinkham, 908 Forum Bldg., Sacramento.

COLORADO: Denver, July 1. Sec., Dr. David A. Strickler, 612 Empire Bldg., Denver.

CONNECTICUT: Hartford, July 8-9. Sec., Regular Board, Dr. Robert L. Rowley, 79 Elm St., Hartford.

CONNECTICUT: New Haven, July 8. Sec., Homeopathic Board, Dr. Edwin C. N. Hall, 82 Grand Ave., New Haven; Sec., Eclectic Board, Dr. James E. Hair, 730 State St., New Haven.

DISTRICT OF COLUMBIA: Washington, July 8. Sec., Dr. Edgar P. Copeland, Apt. 104, Stoneleigh Court, Washington.

HAWAII: Honolulu, July 14-17. Sec., Dr. G. C. Milnor, 401 Beretania St., Honolulu.

INDIANA: Indianapolis, July 8-10. Sec., Dr. William T. Gott, No. 333 State House, Indianapolis.

MAINE: Augusta, July 15-16. Sec., Dr. Adam P. Leighton, Jr., 192 State St., Portland.

MASSACHUSETTS: Boston, July 8-10. Sec., Dr. Charles E. Prior, Room 144, State House, Boston.

NEW MEXICO: Albuquerque, July 14. Sec., Dr. W. T. Joyner, Roswell.

NORTH DAKOTA: Grand Forks, July 1-4. Sec., Dr. G. M. Williamson, Grand Forks.

OKLAHOMA: Oklahoma City, July 8-9. Sec., Dr. J. M. Byrum, Shawnee.

OREGON: Portland, July 1-3. Sec., Dr. Urling C. Coe, Stevens Bldg., Portland.

PENNSYLVANIA: Philadelphia and Pittsburgh, July 8-12. Sec., Dr. George Becht, Harrisburg.

RHODE ISLAND: Providence, July 4-5. Sec., Dr. B. U. Richards, State House, Providence.

SOUTH DAKOTA: Sioux Falls, July 15. Director, Division of Medical Licensure, Dr. H. R. Kenaston, Bonesteel.

UTAH: Salt Lake City, July 1. Director of Registration, Mr. J. T. Hammond, Salt Lake City.

WASHINGTON: Olympia, July 8. Sec., Mr. Wm. Melville, Olympia.

WEST VIRGINIA: Martinsburg, July 8. Sec., Dr. W. T. Henshaw, Charleston.

AN EXPERIMENT IN INTERDEPARTMENTAL CORRELATION *

W. F. PETERSEN, M.D.
CHICAGO

In view of the interest aroused by the recent discussions by Flexner, Cushing, Edsall and Wilbur concerning medical education and the very definite effort that is being made to integrate the preclinical and the clinical years, it may not be amiss to present a brief outline of an interdepartmental course as offered at the University of Illinois during the last year. The objectives were threefold: To present a clinical subject in a well rounded but concise fashion and in logical sequence to students early in their course (second year); secondly, to interest the preclinical instructors in the clinical work and the clinical men in the recent developments of the underlying sciences, and finally to determine the desirability or the feasibility of the further development of such courses in the curriculum. We have been impressed with the reasons advocated for bringing about earlier contact with clinical medicine. Elemental pedagogy would seem to demand a measure of such a tonic without for an instant detracting from the propriety of teaching the fundamental sciences as sciences rather than a adjuncts of the clinics. Neglect of this stimulus has, it would seem to us, made automatons of many students in their preclinical years.

We have had approximately ninety hours available at the end of the sophomore year, and have selected the subject of nephritis as optional for a group of twenty students. Nephritis was selected because of its fundamental importance for the student, because of its manifold contacts in all departments of medicine, and because it is usually considered a difficult subject to teach. Other diseases that would have been more readily presentable might have been chosen.

The material was presented in the form of lectures, clinics, dispensary demonstrations, laboratory work and demonstrations, and student seminars. The arrangement was as given in the accompanying schedule. The seminars usually preceded the formal presentation of the subject, and prepared the student so that an informal discussion with questions might follow after each lecture or clinical demonstration.

We have found that a course of this nature is quite feasible, if guided by an instructor responsible for its management. It involves no great hardship on the full-time staff or on the clinical instructors. Indeed, in many instances the optional group was merely taken into advanced clinical courses so timed that the subject of nephritis was scheduled to fit into the proper date. There was every evidence of whole-hearted cooperation on the part of the clinical instructors.

Schedule

Subject	Presentation	Lecturer	Department
Introduction; historical	Lecture	Petersen	Pathology
Acute nephritis	Clinic	Williamson	Medicine
History, uroscopy, etc.	Lecture	Petersen	Pathology
Chronic nephritis	Clinic	Williamson	Medicine
Embryology	Lecture	Weatherford	Anatomy
Microscopic anatomy	Lecture-demonstration	Eycleshymer	Anatomy
Chronic nephritis	Dispensary-clinic	Moore	Medicine
Chemistry of Normal metabolism	Lecture	Welker	Physiologic chemistry
Physiology of the kidney	Lecture-demonstration	Dryer	Physiology
Chemistry of blood and urine	Lecture	Welker	Physiologic chemistry
Physiology of urine secretion	Lecture	Richards, U. of Pa.	(Guest)
Hyperpiesis	Dispensary-clinic	Moore	Medicine
Capillary microscopy	Laboratory-demonstration	Brough	Pharmacology
Pathology of nephritis	Lecture	LeCount, U. of C.	(Guest)
Pathology of nephritis	Lecture-demonstration	Jaffé	Pathology
Infection and nephritis	Lecture	Davis	Pathology
Experimental nephritis and edema	Lecture-demonstration	Petersen	Pathology
Experimental nephritis and edema	Lecture-demonstration	Levinson	Pathology
Blood chemistry in nephritis	Lecture-laboratory	Hughes	Physiologic chemistry
Blood chemistry in nephritis	Lecture-laboratory	Hughes	Physiologic chemistry
The urine in nephritis	Lecture-laboratory	Pilot	Pathology
Renal function tests	Clinic-demonstration	Culver	Urology
Pharmacology of the kidney	Lecture-demonstration	McGuigan	Pharmacology
Uremia	Lecture	Petersen	Pathology
Differential diagnosis of kidney diseases	Lecture	Saelhof, McCormick Institute	(Guest)
Nephritis in children	Clinic	Hess	Pediatrics
Cardiorenal disease	Lecture	Tice	Medicine
Ophthalmology and nephritis	Lecture-clinic	Brown	Ophthalmology
Nephritis and pregnancy	Lecture	Bacon	Obstetrics

The students have shown decided interest. The idea, so frequently advanced, that the second year student is not sufficiently prepared to understand clinical subjects seems to us both fallacious and pernicious. The material presented has not been beyond their comprehension. On the contrary, their seminar discussions have demonstrated that their grasp of the subject has been excellent.

As a result of our experience, we hope ultimately to develop courses of this character to a considerable extent. With a small student body and an adequate full-time staff, much of the material now crowding the fundamental courses might profitably be presented in courses of this character, which bring about a close coordination of the basic biologic phenomena underlying clinical manifestations of disease.

* From the University of Illinois College of Medicine.

New York January Examination

Mr. Herbert J. Hamilton, chief, New York State Professional Examination Bureau, reports the written examination held at Albany, Buffalo, New York and Syracuse, Jan. 29-Feb. 1, 1924. The examination covered 8 subjects and included 10 questions. An average of 75 per cent. was required to pass. Of the 172 candidates examined, 112, including 2 osteopaths, passed, and 60 failed. The following colleges were represented:

PASSED		
College	Year Grad.	Number Licensed
Yale University	(1920)	1
Georgetown University	(1921), (1922, 3), (1923, 4)	8
George Washington University	(1919)	1
Northwestern University	(1923, 2)	2
University of Illinois	(1922)	1
Tulane University	(1921, 2)	2
Johns Hopkins University	(1919), (1921), (1923)	3
University of Maryland	(1915)	1
Boston University School of Medicine	(1920), (1922)	2
Harvard University	(1921), (1922, 3)	4
Tufts Coll. Med. School	(1916), (1920), (1922, 2), 1923, 2)	6
University of Michigan Med. School	(1918), (1920), (1923)	3
University of Minnesota	(1919), (1922, 2)	3
University of Nebraska	(1920), (1923)	2
Columbia University	(1921), (1922, 2) (1923, 7)	10
Cornell University Med. College	(1921), (1922, 2) (1923, 3)	6
Fordham University	(1912)	1
Long Island College Hospital	(1921), (1923)	2
New York Homeopathic Med. Coll. and Flower Hosp.	(1917)	1
Syracuse University	(1922), (1923), (1924)	3
University of Buffalo	(1923)	1
University and Bellevue Hosp. and Med. College	(1922, 2)	2
University of Oklahoma	(1922)	1
Hahnemann Medical Coll. and Hosp. of Philadelphia	(1923)	1
Jefferson Medical College	(1908), (1918), (1920), (1923, 3)	6
Medico-Chirurgical College of Pennsylvania	(1899), (1911)	2
University of Pennsylvania	(1921), (1923)	2
University of Pittsburgh	(1922)	1
Woman's Medical College of Pennsylvania	(1922)	1
Medical College of the State of South Carolina	(1920)	1
Vanderbilt University, Nashville	(1921)	1
University of Vermont	(1923, 2)	2
McGill University, Quebec	(1912), (1918), (1923)	3
University of Toronto	(1902)	1
Western University, Ontario	(1919)	1
University of Prague, Czechoslovakia	(1921)*	1
University of Vienna, Austria	(1893),* (1920),* (1922)*	3
University of Halle, Wittenburg, Germany	(1920)*	1
University of Heidelberg, Germany	(1919),* (1920)*	2
University of Leipzig, Germany	(1903)*	1
University of Wurzburg, Germany	(1923)*	1
University of Lvow, Poland	(1920)*	1
National University, Athens, Greece	(1903)*	1
University of Budapest, Hungary	(1911),* (1912),* (1919)*	3
University of Catania, Italy	(1907)*	1
University of Naples, Italy	(1911),* (1921)*	2
University of Rome, Italy	(1914)*	1
University of Basel, Switzerland	(1917)	1
University of Berne, Switzerland	(1922)*	1
Syrian Protestant College, Beirut, Syria	(1905),* (1906)	2
Osteopaths		2

FAILED		
College	Year Grad.	Number Failed
Yale University	(1902)	1
Howard University	(1921), (1923)	2
Chicago College of Medicine and Surgery	(1914)	1
College of Physicians and Surgeons, Chicago	(1902)	1
Tulane University	(1923)	1
Johns Hopkins University	(1919)	1
University of Maryland	(1923)	1
Boston University	(1922)	1
Tufts College Medical School	(1921)	1
Columbia University	(1905), (1918), (1922)	3
Hahnemann Medical College and Hospital, Philadelphia	(1922)	1
Jefferson Medical College of Philadelphia	(1917), (1921)	2
Long Island College Hospital	(1923)	1
University of Buffalo	(1922)	1
University of Pennsylvania	(1922), (1923)	2
Vanderbilt University, Nashville	(1920)	1
University of Toronto	(1921)	1
University of Vienna, Austria	(1922, 2)*	2
University of Breslau, Germany	(1914)*	1
University of Freiburg, Germany	(1904)*	1
University of Budapest, Hungary	(1909),* (1910),* (1912),* (1918, 2),* (1919),* (1920)*	7
University of Szegedin, Hungary	(1914)*	1
University of Naples, Italy	(1899), (1905),* (1911),* (1915),* (1916),* (1917),* (1918),* (1919, 2),* (1920, 3),* (1921, 2)*	14
University of Palermo, Italy	(1920),* (1921)*	2
University of Rome, Italy	(1912),* (1920),* (1922)*	3
University of Siena, Italy	(1920)*	1
University of Berne, Switzerland	(1910)	1
Central Turkey College, Ottoman	(1886)*	1
Osteopaths		4

ENDORSEMENT OF CREDENTIALS

Mr. Hamilton also reports that 5 candidates were granted license by endorsement of credentials from Feb. 27 to April 25, 1924. The following colleges were represented:

College	Year Grad.	Endorsement with
University of Illinois	(1920)	Wisconsin
University of Cincinnati	(1910), (1920)	Ohio
Woman's Medical College of Pennsylvania	(1894) (1922)	Indiana Nat. Bd. Md. Ex.

Mr. Hamilton also reports that 12 candidates received the endorsement of their credentials on the basis of eminence and authority in the profession, from Feb. 27 to April 25, 1924. The following colleges were represented:

College	Year Grad.	Endorsement with
College of Physicians and Surgeons, Los Angeles	(1914)	California
Yale University	(1912)	Connecticut
Hahnemann Medical College, Chicago	(1906)	Illinois
Louisville Medical College	(1904)	Kentucky
University of Louisville	(1912)	Kentucky
University of Maryland	(1915)	Maryland
Tufts College Medical School	(1908)	Mass.
University of Michigan	(1915)	Michigan
Jefferson Medical College	(1912)	Penna.
Western Pennsylvania Medical College	(1896)	Penna.
Woman's Medical College of Pennsylvania	(1912)	Connecticut
Royal College of Surgeons, England	(1908)	England

* Graduation not verified.

Social Medicine and Medical Economics

PUBLICITY IN CANCER

HARRY C. SALTZSTEIN, M.D.
DETROIT

Results of publicity are often indirect, and sometimes difficult to measure accurately.

In this regard, medical topics are like other fields that have been subjects of popular propaganda: after considerable expenditure of effort and expense, one may wonder just what has been accomplished. Has a definite message been conveyed, or has the popular mind been confused, and an untoward reaction of unwarranted fear of danger been produced? For this reason, the data recorded here are presented. I believe the figures show that publicity can be considered an important factor in obtaining the best results in the treatment of cancer, just as roentgen-ray improvements or technical refinements are. Though this is not at all new, its significance and its potentialities for improvement of end-results may warrant further emphasis.

During the four days Feb. 17-20, 1924, free cancer diagnosis clinics were held in all Detroit hospitals, under the auspices of the Wayne County Medical Society. In connection with the activities of "Cancer Week," it was possible to give these clinics wide newspaper publicity. Concentrating such activities into a "Week" creates an issue, a drive, a campaign.[1] Facts about cancer will then be of local interest, and after an introductory paragraph of local news, newspapers will print information about the disease. Drab statistics, didactic facts, which otherwise would not have found their way into the columns of a busy metropolitan daily, were thus displayed under such headings as "Cancer Warnings Out," "Drive to Warn City of Cancer," "Cancer Clinic Use Is Urged" and "Expert Comes to Aid Cancer Campaign." Fifty-eight newspaper items were thus secured, each containing some information about cancer.

More than 1,100 persons applied to eight Detroit hospitals during the four days for examinations for cancer. Almost 100 wrote to the Wayne County Medical Society after the campaign closed, asking where they could get the examination. The accompanying tabulations are based on the data of 874 examinations, the records of which were turned in to the committee.

In all, forty-two cancers were discovered, or 4.8 per cent. of the total examinations. These figures represent only those cases in which the existence of the growth was unsuspected or improper or inadequate treatment was advised or given. Hopeless cancers, or those under adequate treatment, were not included in the tabulation. In addition, seventy-five pre-

1. The campaign was made financially possible through the Chase Cancer Fund of Harper Hospital and the generosity of Dr. Fred T. Murphy.

cancerous conditions, or 8.6 per cent. of the total, were discovered.

The most consistent results were seen in breast lesions. There were thirty-nine definite breast tumors, sixteen carcinoma (as far as clinical examination is accurate), and twenty-three benign tumors. As near as one could tell from the records, most of the breast cancers had no axillary involvement. Thus, only 40 per cent. of the series were malignant and most of these were early—a very favorable group when compared to published series. There was a host of other cases—painful breasts, chronic cystic mastitis and other early benign lesions for which no treatment was indicated.

There were eight carcinomas of the uterus.

TABLE 1.—*Examinations at Various Hospitals*

	Examinations
Harper Hospital	367
Receiving Hospital	163
Ford Hospital	120
Grace Hospital	117
Providence Hospital	41
St. Mary's Hospital	29
Deaconess Hospital	26
St. Joseph's Hospital	11

Mouth lesions presented twenty-five precancerous conditions and one early suspicious induration of the tongue. Thirteen of these precancerous lesions seen at Harper Hospital were thus distributed: irritation from teeth and gum, two cases; deep fissures, two; warts, small benign tumors of tongue, four; persistent ulcers, two; leukoplakia, two; syphilis, one.

These figures are interesting when considered in the light of such studies as those of Bloodgood.[2] In his series of 160 cases of cancer of the tongue, 154 started from one of the foregoing benign conditions. Furthermore, in a group of benign tongue lesions similarly studied, "with hardly an exception, the patient sought advice because he had read something in the daily press or in magazines, or heard a lecture about the danger of cancer developing in an innocent painless area of irritation in the mouth." In routine surgical practice without publicity, one does not frequently see these slight precancerous mouth lesions, yet in response to publicity, thirteen mouth cases at one hospital clinic showed every variety of precancerous mouth condition. The significance is that while all of these precancerous conditions are easily and simply cured, only 12 per cent. of tongue cancers are cured.[2] Cancer of the tongue is a preventable rather than a curable disease.

Other figures from the clinics are: seven cancers of the face discovered; fourteen pigmented moles; five cancers of the lip; eight benign lip lesions; one tumor of the parotid; one tumor of the kidney; two epulides; two cases of Paget's disease of the nipple; one cancer of the stomach, and one colon cancer.

Though many persons came to the clinics unduly perturbed and alarmed, fully 60 per cent. had some ailment for which they should have further medical or surgical treatment. The most striking thing was the large number of persons with chronic dyspepsia, most of whom were not being systematically cured of their "stomach trouble." At Harper Hospital, ninety-six out of the total of 367 complained of stomach trouble; at Ford Hospital, twenty-seven out of 120. Many of these were nervous persons with imaginary complaints; many had had unsuccessful encounters with the medical profession; but there were several in whom considerable study would be necessary to make accurate diagnosis; and there were many who showed unmistakable peptic ulcer, chronic appendicitis or gallbladder disease. The important thing was that the members of this large group were content to suffer mildly, not concerned about themselves until aroused by the publicity of the campaign.

Dr. Rankin of North Carolina has emphasized the fact that there is a great unoccupied field of medicine, from three to five times the size of the present medical range. It is called the "development of the private practice of preventive medicine," and concerns the detection of early disease, advice about personal hygiene, and health examinations. It is almost altogether an augmentation and expansion of the private practice of medicine. One cannot glance over these records of dyspepsia, pelvic tumors, pyorrhea and chronic appendicitis, mostly untreated, without feeling the truth of that idea.

306 Kresge Building.

TABLE 2.—*Cancer and Precancerous Conditions Discovered*

	Total	Hospitals						
		Harper	Receiving	Ford	Grace	Providence	St. Mary's	Deaconess	St. Joseph's
Number of admissions...	874	367	163	120	117	41	29	26	11
Cancer of the									
Face	7	3	..	3	1	..	..	..	..
Lip	4	3	..	1	..	..	..	..	..
Tongue	1	1	..	..	..	..	..	..	..
Jaw	2	1	..	..	1	..	..	..	..
Stomach	1	..	..	1	..	..	..	..	..
Colon	1	..	..	1	..	..	..	..	..
Rectum	0	..	..	..	..	..	..	..	..
Breast	16	7	3	1	2	..	3	..	..
Uterus	8	4	2	..	..	2	..	..	..
Parotid	1	1	..	..	..	..	..	..	..
Kidney	1	1	..	..	..	..	..	..	..
Total cancers	42	21	5	7	4	2	3		
Precancerous:									
Pigmented mole	14	9	2	1	2	..	..	..	..
Lip, face	8	3	2	2	..	..	1	..	..
Benign tumor of the breast	23	11	5	3	1	..	1	2	..
Keratosis, skin papilloma	10	6	3	..	1	..	..	..	..
Tongue: wart, leukoplakia, fissure	17	12	2	3	..	..	..	..	..
Cervix papilloma	1	..	..	..	1	..	..	..	..
Rectal polyp	1	..	..	1	..	..	..	..	..
Ovarian tumor	1	..	..	..	1	..	..	..	..
Total precancerous	75	41	14	10	6	..	2	2	

Book Notices

OBSTETRICS FOR NURSES. By Joseph B. DeLee, A.M., M.D., Professor of Obstetrics at the Northwestern University Medical School. Seventh edition. Cloth. Price, $3. Pp. 621, with 274 illustrations. Philadelphia: W. B. Saunders Company, 1924.

Since the appearance of the first edition of this book, almost two years ago, it has been thoroughly revised and completely reset, so that the seventh edition is quite up to date and represents essentially a new book. In its scope, this volume is the most comprehensive of all the textbooks on obstetrics for nurses. No doubt, many will question whether or not a nurse actually requires all the facts of anatomy and physiology that are here included. However, the individual instructor, having all the material available, may well select for study by the nurses only those portions which he, himself, believes are necessary. In our previous review of this book, attention was called to certain difficulties of English construction. Similar difficulties still remain, although the large majority of sentences are easily understandable. For example, the following sentence (page 71) might easily bear revision: "If one observes a labor critically, the process makes the impression of being a mechanical operation, consisting of the action of some expellant power on the fetus and placenta, forcing them through the maternal

2. Bloodgood, J. C.: Cancer of the Tongue a Preventable Disease, J. A. M. A. 77:1381 (Oct. 29) 1921.

parts into the external world." In an attempt to make the book complete, there are discussions of all the various forms of anesthesia used during labor. The following statement appears concerning ethylene: "Ethylene is the very latest anesthetic. It is a gas and is used like nitrous oxid. It smells like garlic and is inflammable, but is said to possess many virtues." It might have been better not to mention ethylene, if nothing more than this was to be said for it. The volume is completed by full discussions of apparatus used during labor, various solutions and recipes, as well as a complete glossary and a series of outlines of the theory of obstetrics. This book is, on the whole, a thoroughly reliable and adequate work, and may be recommended to all requiring a textbook of this character.

HEARING. By Robert Morris Ogden, Professor of Education in Cornell University. Cloth. Price, $3.50. Pp. 351, with 18 illustrations. New York: Harcourt, Brace & Co., 1924.

While ostensibly written for the lay reader, this volume will appeal more particularly to the psychologist, the teacher and student of music, and specialists in diseases of the ear. It is written without regard to lay readers' knowledge of physics and physiology, and is therefore beyond the average comprehension. It is nevertheless a complete study of the physics of sound, of musical sounds, of rhythm, cadence and linguistic sounds. A special chapter on the pathology of hearing gives in simple form the fundamental tests used by otologists and the common pathologic conditions associated with defects of hearing. Emphasis is laid especially on the necessity of psychologic as well as physiologic determinations. The final chapter deals with musical education and offers many practical hints.

BLOOD PRESSURE, CAUSE, EFFECT AND REMEDY. By Lewellys F. Barker, M.D., and Norman B. Cole, M.D. Cloth. Price, $1.25. Pp. 154. New York: D. Appleton & Co., 1924.

This volume aims to be an outline in readable English of important facts regarding blood pressure. It includes not only the facts regarding the effects of high and low blood pressure on the body, but also enough anatomic detail to permit some judgment by the layman of the way in which the symptoms are brought about. The most important chapter, so far as the average reader is concerned, is the final chapter, "What to Do?" which includes simple directions for personal hygiene, and might well be used by any one, as well as those affected with disorders of blood tension. The book is well written, and may safely be recommended to any lay reader.

HANDBUCH DER RÖNTGENTHERAPIE. Herausgegeben von Prof. Dr. Paul Krause, Geh. Medizinalrat, Direktor der Medizin. Universitätspoliklinik in Bonn. Lieferung 5: Die therapeutischen Röntgenbestrahlungen vom pathologisch-anatomischen Standpunkte. Von Dr. P. Prym, a. o. Professor an der Universität Bonn. Paper. Pp. 311, with 44 illustrations. Leipsic: Werner Klinkhardt, 1924.

The author's endeavor was to collect all the known facts concerning the changes following the irradiation of tumors. For this purpose he scrutinized the world's literature on the subject, and he reports also the results of his own investigations. The basic point of view of this study was to determine whether the structural peculiarities encountered were to be considered as produced by the irradiation or whether they were due to the spontaneous variation of the pathologic growths. In myelotic leukemia, in spite of long continued intense irradiation, no histologic changes could be found that with any degree of certainty could be considered as a product of the irradiation. The changes observed in the liver and spleen may possibly be adjudged to the influence of the rays; but changes of this character are known also to develop spontaneously. The disease, as a whole, progresses in spite of all local changes. In tuberculosis, only large doses of very hard rays seem to influence this process favorably. As a result of the treatment, if successful, encapsulation of tuberculous foci and local cicatrization were observed. A direct bactericidal action of the rays on the tubercle bacillus is, to say the least, doubtful. The final histologic picture is identical with that of a spontaneous healed local tuberculosis. Histologic changes in struma tumors due to irradiation could not be ascertained, but it is possible that pericapsular adhesions may have been produced. Shrinkage of hyperplastic tissue in hypertrophy of the prostate could not be demonstrated. Sarcomas are pronouncedly radiosensitive. Ten hours after irradiation, the tumor cells are destroyed, giving a clear picture of karyorrhexis. The first reactive changes of the fibrous tissue become evident a few weeks after the irradiation, to be followed later on by cicatrization and pigmentation. Histologic investigation does not permit any definite conclusions concerning the effect of rays on uterine myomas. The author is inclined to believe that in mammary cancer the roentgen rays primarily damage the cancer epithelium, which is followed by luxuriation of the fibrous tissue. The detailed histologic structure of a mammary cancer does not furnish any pointers as to the possible expectations concerning the efficacy of irradiation. In cancers of the cervix, the glands of the uterine mucosa appeared to be well preserved, while the cancer cells showed all signs of disentegration. The author's general conclusions are that practically all changes in tumors observed after irradiation may also occur spontaneously; therefore such changes may not be considered as specific for the influence of therapeutic rays. With the histologic methods available, we are not in a position to determine with any assurance whether a tumor was exposed to therapeutic rays or not. The cells constituting a cancer are of different radiosensibility—the persistence of parts of the cancer in spite of the irradiation may be another example of the survival of the fittest. The assumption of a so-called stimulating dose is doubtful. Successful irradiaion is characterized by the destruction of the tumor cells, while the surrounding tissues are preserved as to their vitality. For therapeutic purposes, the rays are to be selected with the purpose that the greatest possible number of tumor cells will be destroyed, while the vascularized fibrous tissue with its inherent defensive forces is preserved. The latter are mobilized and reenforced by the disintegration of the tumor cells.

DIETETICS FOR NURSES. By Julius Friedenwald, M.D., Professor of Gastro-Enterology in the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, and John Ruhräh, M.D., Professor of Diseases of Children in the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore. Fifth edition. Cloth. Price, $2.25 net. Pp. 474. Philadelphia: W. B. Saunders Company, 1924.

Any one who has attempted to teach dietetics to nurses soon realizes that his problem lies in telling them enough but not crowding too much. To tell them enough requires careful pruning of the tree of dietetic knowledge: to tell them too much results in a pitiable confusion. It is much more important for the nurse to realize the general therapeutic importance of food than to understand the intricacies of metabolic processes; it is simpler to expect her to prepare a decent tray (under orders) than to plan a diabetic diet. This book will help her along these lines. Much "new" is purposely left out of the book until "the test of a few years of experience."

HYGIENE OF THE VOICE. By Irving Wilson Voorhees, M.S., M.D., Assistant Surgeon to the Manhattan Eye, Ear and Throat Hospital. Cloth. Price, $2.50. Pp. 212, with 18 illustrations. New York: the Macmillan Company, 1923.

Dr. Voorhees has given especial attention to the care of the voice, particularly in singers and public speakers, and he has contributed frequently on the subject both to medical and to lay literature. He believes that training of the voice should be begun as soon as the child can use language intelligently, and that proper physical hygiene is necessary for the singer, as well as a special hygiene directed to the care of the throat. A special section is devoted to the care of the common cold, and the great importance of neglecting simple laryngitis is emphasized. Special sections are devoted also to the tonsils, to throat disorders in singers, to hay-fever, and to acute and chronic infections. An appendix provides an outline for practice in breathing and in voice production. The work is practical, scientific, and well worth the attention of any one interested either in musical education or in the care of the normal throat.

Medicolegal

Negligence Imputable to Operating Surgeons

(Aderhold et al. v. Bishop (Okla.), 221 Pac. R. 752)

The Supreme Court of Oklahoma says that the plaintiff, a school teacher named Bishop, employed the defendants, who were partners in the practice of medicine and surgery, to perform an operation for the removal of a goiter from which she was suffering. The operation was performed at a sanatorium that was in fact a general hospital and training school for nurses, which provided all modern instruments of surgery, an operating room, and skilled nurses, but which had no medical staff and provided neither physicians nor surgeons. While the plaintiff was on the operating table, a pan of hot water, which was kept replenished, was placed between her feet, and the head nurse immersed in the water and wrung out gauze cloths, which she handed to the operating surgeons to be used in taking up the blood that oozed from the incision. It was afterward discovered that the plaintiff's feet and ankles had been severely burned either by the hot water dripping on them, or from the pan resting against them. It was not denied that the burn was the result of a want of care on the part of the head nurse and other employees of the hospital in the handling of the pan of hot water. This left the question of whether or not the admitted negligence of such general employees of the hospital was imputable to the operating surgeons, and this court believes that the question should be answered in the affirmative.

While the head nurse and her assistants were the general employees of the sanatorium, they were nevertheless, during the time required for the actual operation, under the direction and supervision of the operating surgeons, and were the servants of the operating surgeons in respect to such services as were rendered by them in the performance of the operation, and for any negligence on the part of such employees in the performance of such services the operating surgeons were liable. An examination of the authorities discloses to this court's satisfaction that the true test of the existence of the relation of master and servant in a given case does not depend on whether the servant was in the general employ of the master, but on whether the master actually exercised supervision and control over the servant during the time he used such servant. A general master may lend the services of his employees to another for a specified purpose and for a short period of time, in which case the individual to whom such general services are let is the master, and responsible for their negligent acts so long as he exercises actual supervision over them.

This court can conceive of no instance in which the application of the doctrine of respondeat superior (let the master answer) could exercise a more salutary influence than in cases of damage arising out of surgical operations. The patient is helpless under the influence of an anesthetic, and absolutely at the mercy of the surgeons performing the operation, and they are charged with the duty to see that no preventable injury results to their patient. Under the modern science of surgery, a surgical operation, with modern hospital appointments, is a complex enterprise. Necessarily, the various agencies that enter into it must be performed by different individuals, under the active supervision and direction of the operating surgeons in charge. If the operating surgeons were not liable for the negligent performance of the duties of those working under them, the law in a large measure would fail in affording a means of redress for preventable injuries sustained from surgical operations.

Furthermore, if these operating surgeons employed the services of the head nurse in the performance of the operation, which was not denied, then they were liable for her negligent conduct in respect of the part performed by her, irrespective of whether such services were those ordinarily given to a patient under like circumstances.

This court is of the opinion that a case of liability was clearly shown, but that a verdict for $12,620 for the plaintiff was excessive on the facts shown, and that the judgment should be reversed, and a new trial granted, unless a remittitur was filed for all in excess of $7,500 and interest thereon from the date of the verdict.

Charitable Corporations—Act of Orderly in Hospital

(Phillips v. Buffalo General Hospital (N. Y.), 202 N. Y. Supp. 572)

The Supreme Court of New York, Appellate Division, Fourth Department, says that after much discussion the law has been settled in that state that a charitable corporation is not totally exempt from liability for the negligent acts of its employees committed within the line of their employment. It is equally well settled that a hospital maintained as a charitable institution is exempt from liability for the negligent acts of physicians and nurses in the treatment of patients. Such exemption from liability has finally been placed squarely on the ground that the patient, on becoming an inmate of such charitable institution, waives all claims of liability growing out of the negligent acts of physicians and nurses that occur during treatment. This is true, even though the patient injured by the negligent act of a physician or a nurse is a paying patient.

The plaintiff in this case was a paying patient. The defendant is a charitable corporation maintaining a hospital. The plaintiff, while being treated, was burned by a hot water bottle negligently placed in the bed with her, while she was unconscious, by an orderly. It was conceded that the defendant would not be liable in an action for negligence if the hot water bottle had been placed in the bed by the nurse in charge of the case. Yet a recovery of a judgment for $750 for damages was permitted, on the theory that the orderly was a servant of the defendant, occupying the same relation to it as superintendent or assistant superintendent, and that for his negligent act the defendant was responsible, under the doctrine of respondeat superior (let the master or superior answer). That judgment, however, is here reversed, and the complaint dismissed, with costs.

It is true that the defendant might be held liable for the negligent act of one of its servants, committed within the scope of his employment, which resulted in an injury to a third person not a beneficiary of its charity. To hold, however, that the plaintiff, on becoming a patient in the defendant's hospital, impliedly waived all right of action for damages growing out of injuries that might be caused by negligent acts of a nurse, but did not waive such right of action if the injury should be caused by an orderly, seems illogical and unjustified. There is no reasonable basis for such distinction.

Liability of One Spouse for Services to the Other

(Ematrudo v. Gordon et ux. (Conn.), 123 Atl. R. 14)

The Supreme Court of Errors of Connecticut says that one Gordon had a scar that extended from the angle of the mouth across the face to the left ear. The plaintiff performed an operation, which greatly improved the man's looks. Afterward the plaintiff sued both Gordon and the latter's wife to recover compensation for the operation, and obtained a judgment against Gordon for $218, but none against his wife; and this court finds no error.

The plaintiff sought to charge Mrs. Gordon, under Section 5275 of the General Statutes of Connecticut, which provides that both husband and wife "shall be liable for the reasonable and necessary services of a physician rendered the husband, wife or their minor child," etc. The reciprocal liability of each spouse for medical services rendered the other is limited to such as are reasonable and necessary, and the obligation of the wife under the statute is neither greater nor less than that of the husband. The latter is liable at common law for reasonable and necessary medical services rendered to the wife. "Physic," as used in its original and broad sense, is included in necessaries. Surgical services undoubtedly stand on the same ground as medical services. So it appears that, in considering the liability of the wife, it may be said by way of interpretative analogy that, in substance, it is the same as the husband's common-law liability for services rendered the wife. If, then, the wife's liability under the statute for surgical services to her husband is equivalent to the liability of the husband for like services

furnished the wife, the court is led to consider the rules affecting the ascertainment of that liability.

The services rendered must be both reasonable and necessary. In this connection, these words have no technical or legal significance differing from their content and sense in the common use. In determining whether any given medical or surgical attention comes within the purport of these words, both reasonableness and necessity are factors in any given case, and must to some extent concur. It is to be determined, in the first place, whether the service to be performed is reasonable, and if so whether the particular operation or treatment is necessary to effect a reasonable object. Sometimes one of these factors may predominate so as practically to control the situation. The necessity might be so great and imminent as clearly to show reasonableness, as when a person is in imminent danger of death or some very serious ill. On the other hand, while in a given case a certain operation or course of treatment may be necessary to promote a desired end, the end itself, in view of the circumstances of the parties concerned, may not be reasonable. In any given case it might well be that the station in life of the parties, their usual style of living, and their pecuniary position in general, being on a liberal and generous scale, would justify charging the wife with the services of a most expert and expensive practitioner of plastic surgery to restore the husband's facial symmetry and comeliness; on the other hand, on account of facts of the same nature, but compelling a contracted mode of life and careful attention to pecuniary outgo, and considering the requirements of a less exacting social environment, it would be unreasonable and unjust to compel a wife, not by reason of her own contract, but as a burden cast on her by statute, to defray a charge such as that just suggested, or, indeed, any charge.

To determine the question, the trier would have to consider in the instant case what was the extent of the family income, the nature of the husband's employment (which was that of a salesman), and whether it was steady or casual; whether or not the appearance of his face after the accident and prior to the operation, which interval was stated to have been a long time, had in fact operated adversely to the continuance or procurement of employment. There was also to be considered the extent to which both husband and wife contributed to the family support, the existence of any invested property, and in general the pecuniary situation of the parties and their social surroundings and general course of life. The trial court reached the conclusion that the operation was only to improve the appearance of Mr. Gordon, and was not a reasonable and necessary operation, so far as charging his wife with liability for the cost. Without any finding as to the station in life, style of living and pecuniary situation of this family, it cannot be held that there was error in drawing the conclusion drawn.

Roentgenograms of Privileged Nature—Examinations

(Hansen et ux. v. Sandvik et ux. (Wash.), 222 Pac. R. 205)

The Supreme Court of Washington says that, in this action to recover damages alleged to have been sustained in a collision of the defendants' automobile with the plaintiffs' truck, in which the plaintiffs were riding, there was no error in denying the defendants' application for the appointment of a physician to examine certain roentgenograms of the injuries to the skull of Mrs. Hansen, which had been taken by her personal physician. As a matter of fact, the plates were examined by a disinterested physician appointed by the court; but the picture taken by the plaintiff's personal physician was in the nature of a private communication between the physician and his patient which, until waived by being introduced in evidence by the plaintiffs, could not be used by the defendants.

Nor was there error in the denial by the trial court of the defendants' application for a physician to examine the plaintiff or her roentgenogram. The application was for a physician of the defendants' own selection. To have granted that would have been error. But the court did appoint a disinterested physician, thus exercising its discretion; and, having done so, it was not error to refuse to permit further physical examination.

Treatment of Wound—Evidence of Negligence

(Miles v. Hofman (Wash.), 221 Pac. R. 316)

The Supreme Court of Washington, in affirming an order granting the defendant a new trial after the jury had found a verdict in favor of the plaintiff for damages for alleged malpractice, quotes the trial judge as stating that the defendant knew the source of the plaintiff's injury—that it had been inflicted by a mad boar. The extent of the penetration neither the defendant nor any one else knew. He swabbed the wound with a cauterizing fluid, made a wet application, and placed the knee in an improvised box splint. All the medical witnesses, except one, testified that this was proper treatment. The one testified that the wound should have been opened at once so that the infection, if any, which had been carried into it by the tusk of the boar could have been destroyed and the wound provided with proper drainage. The others said that to have opened the wound would have been dangerous because there was danger of spreading the infection carried into the wound by the boar's tusk, and also danger of cutting the sac containing the synovial fluid. What was proper treatment under the circumstances was a question to be determined by medical testimony. The treatment actually given, according to the great preponderance of the evidence, was the treatment ordinarily given in cases of this kind in that and similar localities. The rule, the judge went on to say he understood, is that when a physician gives the treatment ordinarily given he cannot be held for malpractice because of bad results. If there are two or more methods of treating an injury, each having the sanction of the medical profession, the choice of one of the methods to the exclusion of the others will not subject the practitioner to damages for malpractice. This part of the judge's memorandum opinion was based on the facts disclosed by the record, and, the supreme court holds, correctly stated the law; i. e., there was reputable medical authority shown by the testimony of expert witnesses for the treatment given, and therefore the defendant could not be held negligent in following that authority.

The supreme court cannot agree with the trial court, however, that there was no evidence of lack of attention. True, the patient was at his home in the country some miles from the defendant's office, but it was shown that he was nursed only by his wife, his daughter, and the wife of a neighbor, none of whom had any experience or training in nursing such cases—conditions that the defendant knew, or should have assumed. Yet, notwithstanding the seriousness of the injury and the results that medical men look for and seek to avoid in such cases, there was no evidence of careful instructions or warning to the nurses, which, as the jury might readily find, should have been given. The absence of such instructions, the infrequency of the defendant's visits, his failure to take the temperature of the patient, and the like, of which there was some evidence, warranted the jury in finding that the defendant, if he had been more diligent in these respects, could have detected the presence of infection, and perhaps that the synovial sac had been penetrated, long before he did. Although the proper treatment was administered in the beginning, yet there may have been negligence in not giving proper instructions, or in not making frequent and sufficient examinations to determine the necessity of a change of treatment. This view would necessitate a reversal of the order granting the defendant's motion for a new trial had there been proof from which the jury might reasonably have inferred that the final results were caused wholly or in part by such want of care; but there was no such proof in the record. Furthermore, a motion for an instructed verdict was properly denied because the state of the record was an admission that there was evidence to go to the jury as to the developments after the plaintiff was taken to a hospital. Then, since the verdict was rendered on the whole case and was indivisible, the trial court could not tell what part of the award, if any, was based on the negligence that the court has been considering; and since there was no evidence that such negligence contributed to or caused the final condition, clearly the evidence on that phase of the controversy was insufficient.

Current Medical Literature

AMERICAN

The Association library lends periodicals to Fellows of the Association and to individual subscribers to THE JOURNAL for a period of three days. No foreign journals are available prior to 1920, nor domestic prior to 1923. Requests should be accompanied by stamps to cover postage (6 cents if one and 12 cents if two periodicals are requested).
Titles marked with an asterisk (*) are abstracted below.

American Journal of Psychiatry, Baltimore

3: 593-855 (April) 1924

Analysis of Recoverable "Dementia Praecox" Reactions. E. A. Strecker and G. F. Willey, Philadelphia.—p. 593.
*Roentgenologic Observations of Gastro-Intestinal Conditions Associated with Mental Disorders. G. W. Henry, White Plains, N. Y.—p. 681.
*Psychic Manifestations in Migraine. F. P. Moersch, Rochester, Minn. —p. 697.
Histopathology of Focal Brain Softening. H. D. Singer, Chicago. —p. 717.
*Acidophil Degeneration in Dementia Praecox. O. F. Kelly, Danvers, Mass.—p. 721.
"Creative Imagination" in Normal Persons and in Mentally Diseased. H. Lundholm, Waverly, Mass.—p. 739.
*Treatment of Psychoneuroses. G. J. Wright, Pittsburgh.—p. 757.
Sociopsychiatric Delinquency Studies from Psychopathic Clinic. T. Raphael, A. L. Jacoby, W. W. Harryman and M. M. Raphael, Detroit.—p. 767.
Demonstration Clinics Conducted by Division on Prevention of Delinquency of National Committee for Mental Hygiene. V. V. Anderson, New York.—p. 779.
Sequels of Epidemic Encephalitis in Children. J. H. W. Rhein and F. A. Ebaugh, Philadelphia.—p. 791.
Diagnosis of General Paresis. N. H. Brush, Santa Barbara, Calif. —p. 801.
Standardization. S. W. Hamilton, New York.—p. 809.
Interrelationship Between Endocrine Disturbances and Psychoneuroses. C. A. Patten, Philadelphia, and A. J. Ostheimer, Jenkintown, Pa.—p. 817.

Gastro-Intestinal Conditions Associated with Mental Disorders.—Henry presents some observations tending to show that visceral position, tonus and motility are affected by different types of psychoses in addition to the variability due to habitus. These observations were made on 100 unselected cases in which no definite organic disorder was found. In the manic phase of affective psychoses there is a definite tendency toward normal or even higher position, toward normal or hypertonic tonus, and normal or even more rapid motility, whereas in the depressive phase of affective psychoses there is a definite tendency toward just the opposite conditions. Paranoid states show a tendency towards higher position, and greater tonus than the paranoid dementia praecox with only a slight degree of hypomotility. Psychoneurotics seem to be prone to hypertonicity or even spasms with perhaps hypomotility. It seems evident that certain definite physiologic visceral changes accompany and are intimately associated with different types of psychoses, and, furthermore, that it seems probable that the so-called normal variations and even some conditions believed to be pathologic may be due in part to mood variations or other tendencies toward psychotic states in the normal individual.

Psychic Manifestations of Migraine.—The psychic findings of migraine are reviewed by Moersch. Of the 1,000 cases reviewed, 15 per cent. manifested mental symptoms, either directly associated with the attack, or in some manner related to the condition. The most common complaint was a mild mental and physical depression, a sense of apathy, dullness, drowsiness, fatigue, lack of energy, anxiety, general distress and fear of impending trouble. In twenty-two of these cases the psychic disturbances were so profound that they might well be considered as transitory psychic episodes. Only one patient showed any evidence of endocrine disturbance.

Acidophil Degeneration in Dementia Praecox.—Kelly calls attention to acidophil degeneration, hitherto described only once and otherwise practically ignored. The possibilities of its presence being the result of tuberculosis or of the method of tissue fixation are considered and discarded. It was found in seven of a group of ten cases clinically diagnosed dementia praecox; of the three cases in which it was not found, two were doubtful diagnoses and one was found at necropsy to be another condition. Of thirty-two cases with the diagnoses other than dementia praecox, two showed acidophil degeneration. On reviewing their records Kelly feels that one probably was a case of dementia praecox, and it is within the bounds of possibility that in the other dementia praecox may have been present in addition to neurosyphilis. Its distribution is considered, especially in relation to symptoms and to Kraepelin's theory of the function of the small and medium pyramidal cells. The cause and significance of acidophil degeneration are at present unknown. At any rate, it adds to the already large amount of evidence that the mental symptoms of dementia praecox are the manifestations of the disordered function of an organically disordered brain.

Treatment of Psychoneuroses.—The purpose of Wright's paper is to show that the majority of the neuroses and psychoneuroses as seen in an active neuropsychiatric practice are benign and open to relatively easy approach and cure. The method of treatment is naturally one of reeducation and readjustment. In the pernicious or malignant cases the same methods are advisable, but some of these cases are so complex in their development that a disproportionate amount of time and effort is required, and such patients should be referred to men specializing in this direction.

Boston Medical and Surgical Journal

190: 865-916 (May 22) 1924

Medical Journalism in New England, 1788-1924. J. Garland, Boston. —p. 865.
Drug Eruptions. C. G. Lane, Boston.—p. 880.
Osteomyelitis of the Ilium in Children. C. Bearse, Boston.—p. 883.

190: 917-964 (May 29) 1924

*Torula Infection in Man: Report of Case. G. H. Hansmann, Boston. —p. 917.
Hirst Transperitoneal Cesarean Section. E. M. Hodgkins, Boston. —p. 920.
Meckel's Diverticulum in Left Inguinal Hernia. T. H. Lanman, Boston.—p. 926.
Case of Lethargic Encephalitis with Choked Disk. D. C. Parmenter and R. C. Cheney, Boston.—p. 928.

Torula Infection in Man.—Stomach trouble, dizziness and nausea were the chief symptoms in the case reported by Hansmann. The temperature was normal. The blood findings were: hemoglobin, 107 per cent.; erythrocytes, 5,340; marked leukocytosis; 81 per cent. polymorphonuclears and 19 per cent. lymphocytes; Wassermann reaction, negative, and blood urea nitrogen, 16 mg. The patient became drowsy and complained of continuous headache. In a week there was a constant tendency to sleep. The pupils reacted promptly to light and the knee jerks were not exaggerated. The neck was very rigid and the patient was stuporous but not lethargic. There was a suggestive Kernig sign. He died about three weeks after entering the hospital. A necropsy was held. The findings bearing on the case were met with in the brain. Along the vessels, emerging from the Island of Reil were numerous translucent nodules surrounded by a greyish zone. Over the cerebrum ten lesions were counted. The cerebellum was adherent to the dura and could not be removed without tearing the cerebellum somewhat. The lesions seemed to be confined entirely to the meninges. Sections of various portions of the brain, other than those including meninges, showed no pathology. Sections of meninges from the region of the pons, cerebellum and Island of Reil showed most marked lesions of an extensive proliferation reaction. In relation to the lesions was an organism which was classified as *Torula histolytica*.

Georgia Medical Association Journal, Atlanta

13: 199-242 (May) 1924

Technician Versus Obstetrician. E. C. Demmond, Savannah.—p. 199.
Insulin and Diet in Diabetes. J. A. Redfearn, Albany.—p. 201.
Mucous Colitis. L. G. Neal, Cleveland, Ga.—p. 204.
Local Anesthesia in Anorectal Diseases. N. W. Baird, Atlanta.—p. 206.
*Chronic Malarial Infection. G. M. Murray, Atlanta.—p. 208.
*Phenolphthalein Eruptions. W. H. Hailey, Atlanta.—p. 210.

Chronic Malaria Cause of Acne and Asthma.—Murray asserts that in his experience chronic malarial infection with its altered blood state is a very frequent cause of acne vulgaris and asthma.

Predeliction of Phenolphthalein Eruptions for Jews.—The case reported by Hailey is the first to be reported from

Georgia. All cases heretofore reported by various observers, in which the nationality of the patient was stated, occurred, in Jews. Hailey's patient was a Jew. He asks: Is this condition more likely to occur in Jews?

Surgery, Gynecology and Obstetrics, Chicago

38: 579-722 (May) 1924

*Ulcer of Abdominal Wall Following Drainage of Abdominal Abscess. T. S. Cullen, Baltimore.—p. 579.

Gastroduodenostomy: Its Indications. C. H. Mayo, Rochester, Minn.—p. 583.

*Bone Changes in Recklinghausen's Neurofibromatosis. B. Brooks and E. P. Lehman, St. Louis.—p. 587.

*Splenectomy in Purpura Hemorrhagica (Thrombocytolytic Purpura, Kaznelson). I. Cohn and I. I. Lemann, New Orleans.—p. 596.

Abscess of Liver Due to Bacillus Aerogenes Capsulatus. C. C. Snyder, Pasadena, Calif.—p. 605.

*Multiple Polyposis of Gastro-Intestinal Tract. J. E. Struthers, Rochester, Minn.—p. 610.

*Growing Power of Periosteal Callus When Transplanted to Costal Cartilages. G. H. Klinkerfuss, St. Louis.—p. 625.

*Operation on Neck of Femur Following Acute Symptoms in Case of Osteochondritis Deformans Juvenilis Coxae. G. L. McWhorter, Chicago.—p. 632.

*Results of Surgery for Migraine. J. A. Buchanan, Pueblo, Colo.—p. 638.

*Cystinuria; Report of Case. A. Harris, Brooklyn.—p. 640.

Diagnosis and Treatment of Gastrojejunocolic Fistula. W. A. Brams and K. A. Meyer, Chicago.—p. 646.

Emphysematous Gangrene; Report of Five Cases. W. F. Gemmill, York, Pa.—p. 650.

Fractures of Lower End of Humerus as Treated in Outpatient Department of Roosevelt Hospital. C. W. Cutler, Jr., and H. W. Cave, New York.—p. 653.

Backache from Vertebral Anomaly. T. A. Willis, Cleveland.—p. 658.

Ureteropyelography in Abdominal Diagnosis. D. N. Eisendrath, Chicago.—p. 666.

Cesarean Technic. G. S. Foster, Manchester, N. H.—p. 674.

Fascia Plication in Repair of Inguinal Hernia. J. A. Pettit, Portland, Ore.—p. 677.

Wax Models in Teaching of Surgery. F. P. Johnson, Portland, Ore.—p. 682.

Chiropodic Surgery: Treatment of Chronic Subungual Hematoma. G. B. Arana, Buenos Aires, Argentina.—p. 688.

Ethylene-Oxygen Anesthesia in Obstetrics and Gynecology. N. S. Heaney, Chicago.—p. 692.

"Reef," "Granny" and "Slip" Knots. K. H. Digby, Hongkong, China.—p. 695.

Ulcer of Abdominal Wall Following Drainage.—The man, whose case is described by Cullen, had a right-sided abdominal abscess about midway between the appendix and gallbladder regions. A right rectus incision was made and the abscess drained. About two days after the operation the incision looked red and inflamed. About sixteen days later there was a wide ulcerated area where the incision had been. About five and one-half weeks after operation the opening into the abdominal cavity had closed and the abdominal muscles were well united, but the ulceration of the skin and fat continued to progress until there was an ulcer of the abdominal wall, fully 12 inches across, which was deep and had necrotic sloughing margins. The margins were cut away with the cautery. The wound took on a healthy appearance. It was well covered with pinch grafts and the patient made a good recovery. At no time was there a fecal fistula, nor was there evidence of escape of pancreatic fluid. No sugar was found in the urine. The only micro-organism found was *Streptococcus brevis*. The Wassermann reaction was negative. There was no evidence of blastomycosis.

Bone Changes in Neurofibromatosis.—Certain bone changes found by Brooks and Lehman in seven cases of this disease seem to them to be characteristic manifestations. These changes were: scoliosis, abnormalities of growth and irregularity of outline of the shafts of long bones including changes which in the roentgenogram appear as subperiosteal bone cysts. Scoliosis, varying in degree, was present in all the cases. Excessive growth in length of long bones was noted in two cases. In one case there was also a marked inequality in the length of the two femurs, but apparently the longer bone was normal. Irregularity in outline of bones was found in five cases, varying from very slight irregularity of the periosteal and cortical structure of the bone to large tumors projecting from the surface of the bone or embedded as cystlike cavities in the structure of the bone. All of the bone changes observed can be explained on the basis of the involvement of the bone by the growth of the tumor tissue which is characteristic of Recklinghausen's disease. These observations emphasize the fact that Recklinghausen's neurofibromatosis is a condition affecting bone as well as skin and nerve. The fundamental process in the disease is one of tumor growth.

Splenectomy in Purpura Hemorrhagica.—The effect of splenectomy in thrombocytolytic purpura is spectacular. Subcutaneous hemorrhages ceased in Cohen's case at once. He also calls attention to the reaction which followed within three hours of the splenectomy. Suddenly the child became pale and showed a marked hyperpnea, with increased fremitus and râles over the entire chest. The skin was hot and dry and the temperature rose to 101.8 F. and there was no restlessness. Nothing about the child suggested hemorrhage or shock. The patient had had only nitrous oxid and oxygen. The similarity of the reaction to that of capillary poisons, such as histamin, forces Cohen to the conclusion that this reaction must have been the result of an overdose of capillary poison suddenly liberated at the time of splenectomy. Histamin produces a loss of capillary tone. In purpura hemorrhagica there is evidence of such a disturbing factor on the capillary tone—the prolonged bleeding time. The manipulation of the spleen probably liberated an excess of this capillary poison, sufficient to produce the reaction.

Multiple Polyposis of Gastro-Intestinal Tract.—Twenty-four cases of multiple polyposis of the gastro-intestinal tract have been observed at the Mayo clinic since February, 1920, twenty of which are reported by Struthers. The predominant symptoms are diarrhea, with the passage of pus and blood, vague abdominal pain and rectal tenesmus. The small intestines are rarely involved. The disease terminates in malignancy in a large percentage of cases. Most marked involvement of the colon is found in the cases which begin as a mild diarrhea and later become chronic. The findings in one patient would tend to confirm the correctness of Menetrier's terminology "gastritis polyposis."

Growing Power of Transplanted Periosteal Callus.—Klinkerfuss made a very extensive experimental study on the growing power of the callus obtained from seven to twenty-one days after cutting into the ulna of rabbits. The results were interesting. Callus grafts do not die, but continue growing after transplantation. Solid bone grafts, in the main, die, are absorbed, and replaced by new bone tissue resulting from the proliferating of osteoblasts of the periosteum, endosteum, and haversian canals. Callus grafts form new bone more rapidly and in greater amount than solid bone transplants. Callus grafts persist as long as solid bone grafts, and become quiescent at about the same time.

Infection Cause of Osteochondritis Deformans Juvenilis.—McWhorter believes that his case adds some evidence to the theory of infection as a cause of the disease entity best known as osteochondritis deformans juvenilis, or Calvé-Legg-Perthes' disease. Clinically the symptoms appeared to be those of an early acute osteomyelitis of the neck of the femur. Only one colony of staphylococcus was grown from material removed from the neck of the femur. The cultures from the shaft of the femur and joint fluid were sterile. There was a definite active focus of infection in the maxillary sinuses with a history of exacerbations and nasal discharge. *Staphylococcus aureus* was cultured from the sinuses. Following osteotomy of the neck of the femur the case progressed to a cure without the usual chronic course.

Results of Surgery for Migraine.—Seventy-five per cent. of 1,335 patients were operated on by surgeons all over the United States from one to seven times for the relief of migraine. The operations varied in magnitude from cerebral decompression and colectomy to circumcision of the clitoris. The end-results from all angles of surgical attack were the same. Not a single patient operated on was cured or relieved more than temporarily, while those patients who were unfortunate enough to have their reproductive organs removed, or have a gastro-enterostomy performed, were made much worse not only so far as the migraine was concerned but generally. In those cases in which a gastro-enterostomy had been performed, the general health was partially or wholly restored to the original status by the undoing of the gastro-

enterostomy. Two cases are reported by Buchanan. Many operations had been performed on one of the patients: amputation of cervix, rectal operation for hemorrhoids, appendectomy, gastro-enterostomy and gastro-enterostomy undone. The headaches continued unabated. The five operations to which this patient had been subjected only tended to debilitate her generally, and had no good influence on the primary condition. In the second case only one operation was performed—an appendectomy. It had no influence on the course of the trouble. Buchanan asserts that migraine is hereditary in man and is transmitted from generation to generation according to the laws of Mendel.

Familial Cystinuria.—Harris found that two other members of the family of his patient (brothers) have cystinuria, one of them with a definite "rheumatic" history, the other having a distinct oxaluria associated with cystin. Two other brothers also showed a marked excess of oxalates.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

British Medical Journal, London

1: 809-846 (May 10) 1924

*Angina Pectoris and Possibilities of Surgical Relief. K. F. Wenckebach.—p. 809.
Minor Injuries of Brain. W. Trotter.—p. 816.
Case of Sclerema Neonatorum. W. G. Nash.—p. 820.
Cerebral Hemorrhage and Congenital Obliteration of Gallbladder and Ducts. H. Gladstone.—p. 820.
Tartar Emetic in Tuberculosis. F. G. Cawston.—p. 820.
Intracardiac Injection of Epinephrin. J. G. Reed.—p. 820.
Acute Obstructive Cholecystitis. J. L. O'Flyn.—p. 821.
Lithopedion: Subsequent Pregnancies. C. L. Spackman.—p. 821.

Angina Pectoris.—Allbutt's theory of angina is endorsed by Wenckebach and its treatment by resection of the depressor nerve is discussed, although doubt is expressed that it will be the operation of choice because so often the nerve is difficult or even impossible to find. Theoretically, this is the safest form of operation because in it only afferent nerves are removed, and the essential augmentory nerves are left uninjured. There is proof that the depressor nerve, on stretching of the aortic wall by high blood pressure, brings about a rapid fall, thus relieving the stress on the aortic wall.

Glasgow Medical Journal

101: 173-252 (April) 1924

Medical Aspects of Samuel Johnson. H. Rolleston.—p. 173.
Problem of Fitness. L. Mackenzie.—p. 192.
Practice of Psychanalysis. D. Yellowlees.—p. 198.
*Case of Alkaptonuria. J. S. Young.—p. 214.

Alkaptonuria.—There was no consanguinity between the patients in the case reported by Young, nor any record of the abnormality in any of the child's antecedents, within two generations at least. There was a definite history of toxic disturbance during antenatal life, the mother having suffered from edema of the lower extremities, headache, sickness and vomiting during the latter part of her pregnancy. Young believes that in view of the comparatively common incidence of albuminuria during pregnancy, and of the extreme rarity of alkaptonuria, the existence of renal symptoms in the mother in her pregnancy must be regarded as a fortuitous circumstance having no bearing on the etiology of the abnormality.

Lancet, London

1: 935-986 (May 10) 1924

*Minor Injuries of Brain. W. Trotter.—p. 935.
*Wasting Disorders of Early Infancy. L. G. Parsons.—p. 939.
*Islets of Langerhans and Zymogenous Tissue of Pancreas. S. Vincent.—p. 947.
Three Cases of Carcinoma of Appendix. H. K. Whittingham.—p. 948.
Psychology of Vertigo. W. F. Menzies.—p. 949.
Case of Rhinosporidium Kinealyi. W. L. Forsyth.—p. 951.
Source of Infection with Heterophyes in Egypt. M. Khalil.—p. 952.

Cause of Traumatic Headache.—In discussing the pathology of traumatic headache, Trotter compares the brain with other viscera inclosed in serous membranes. As with other serous membranes, it is probable, therefore, that the most effective pain-producing stimulus is stretching. The arrangement of the dural septa is such that variations in the amount of intracranial pressure and inequalities in its distribution tell on them by causing alterations in tension. Thus it comes about that headache of organic origin is a direct expression of disturbances if intracranial pressure however these may be produced. Such a conclusion is in obvious agreement with clinical experience. It is probable that in nature a reduction in intracranial pressure is but rarely the cause of headache. It is plain, however, from the arrangement of the dural septa, that a local reduction in pressure can give rise to painful stretching until the disturbance has become equalized. This is the mechanism by which is produced the headache that often follows the withdrawal of fluid by a lumbar puncture. When a disturbance of intracranial pressure is severe or rapidly progressive the consequent headache is continuous. When the disturbance is moderate, and either stationary or only slowly progressive, the headache is apt to be only paroxysmal. This latter is the case with a certain number of slow growing cerebral tumors in their early stages, and is almost characteristic of traumatic headaches. The increase of tension is associated with one or other of two conditions of the brain itself. When the headache has followed an injury causing concussion, the brain is edematous and exudes an undue amount of fluid when exposed. When the headache has followed a localized blow on the head, and the region struck has been explored, the brain shows by its swelling and blood staining that it is the seat of a localized bruising.

Rammstedt Operation for Pyloric Stenosis.—Parsons concludes this series of lectures with the dictum that the rational treatment of pyloric stenosis of infants includes the performance of the Rammstedt operation at the earliest possible moment.

Islands of Langerhans Not Separate Organs.—Vincent concludes his review by stating that the islets of Langerhans are not separate and distinct organs. They represent temporarily modified portions of the secretory tubules of the pancreas. By certain modes of staining some cells of the islets may be differentiated from others, but the differentiation may point to different stages of activity and not indicate two distinct types of cell. Moreover, these are signs of a similar differentiation among the cells of the zymogenous tissue. The islets are anatomically continuous with the zymogenous tubes, and the two kinds of tissue may be seen to merge one into the other. During inanition and under other circumstances the amount of islet tissue is regularly and markedly increased.

Medical Journal of Australia, Sydney

1: 381-404 (April 19) 1924

Surgical Anatomy of Acute Appendicitis. H. C. R. Darling.—p. 385.
*Unusual Combination of Pathologic Lesions in Infant. R. Southby p. 391.

SUPPLEMENT

Irregularities in Iso-Agglutination. A. H. Tebutt.—p. 234.
"Biochemical Index" in Natives of New Guinea. G. M. Heydon and T. W. Murphy.—p. 235.
Types of Infection in Lobar Pneumonia and Influence of Serum Treatment. B. A. Warner.—p. 236.
Statistical Review of Tuberculosis in Australia. J. H. L. Cumpston.—p. 237.
Incidence of Tuberculosis in Australia. W. J. Penfold.—p. 252.

Sequels of Pneumonia and Measles.—Southby's patient, aged 14 months, died in convulsions. She had previously had pneumonia and measles. The necropsy disclosed pulmonary abscess secondary to pneumonia, otitis media with secondary septic meningitis and hemorrhagic glioma.

Practitioner, London

112: 273-340 (May) 1924

Present Position of Surgery of Labyrinth. W. Milligan.—p. 273.
Risks of Prostatectomy. K. M. Walker.—p. 278.
Early Diagnosis of General Paralysis. G. W. T. H. Fleming.—p. 287.
Diagnosis of Subacute Osteomyelitis. C. E. Shattock.—p. 296.
Rheumatism in Children. H. T. Ashby.—p. 303.
French Views on Heart Disease. F. Moor.—p. 308.
Nature of Stuttering. E. W. Scripture.—p. 318.
Subacute Infective Endocarditis. H. W. Jones.—p. 327.

South African Medical Record, Cape Town

22: 137-160 (April 12) 1924

Curability and Treatment of Early Syphilis. B. Bernstein.—p. 149.

Annales de Médecine, Paris

15: 365-458 (May) 1924

*Chronic Miliary Tuberculosis. R. Burnand and L. Sayé.—p. 365.
Albumosemia and Liver Function. Piéchaud and Aubertin.—p. 387.
*Basal Metabolism in Postencephalitic States. Van Bogaert.—p. 403.
Tuberculosis and Typhoid. A. Pellé.—p. 411.
Tuberculosis of Nervous Centers. Bertrand and Médakovitch.—p. 419.

Chronic Miliary Tuberculosis.—Burnand and Sayé describe practically apyretic and chronic types of miliary tuberculosis of the lungs. The disease may last for years. Roentgen rays are the main diagnostic help.

Basal Metabolism and Postencephalitic States. — Van Bogaert determined the basal metabolism in twelve patients with various postencephalitic syndromes, such as parkinsonism, obesity and genital disturbances. The figures obtained were normal.

A. M. M., Mexico, D. F.

2: 159-216 (May) 1924

*The Typhus Problem. T. G. Perrin.—p. 163.
Estimating the Carbohydrate Tolerance in Diabetics. F. de P. Miranda.—p. 185.
*Myiasis in the Nose. D. Gurria Urgell.—p. 192.
The Encroaching Evil. I. Chávez.—p. 196.

Microbiology of Typhus.—Perrin studied the digestive and copulatory apparatus in 508 lice from healthy persons. Bodies resembling rickettsia were found in from 8 to 45 per cent. They differed from the prowazeki type only in the fact that they were not frankly intracellular. The prowazeki occurs in the blood in typhus in such small numbers that it is difficult to detect it. The typhus clinical picture identifies the rickettsia usually, instead of the rickettsia identifying the typhus. Vaccine treatment and prevention is still in the tentative stage, so that the identification of the causal germ of typhus has not proved of such paramount importance as anticipated. The whole typhus question is solved, however, by the fact that the causal germ has never been found in any insects except the louse.

Larvae in the Nose.—Gurria Urgell declares that nothing is so effectual and so simple as inhalation of 5 or 6 drops of chloroform several times a day for dislodging and expelling larvae in the nasal passages. In a case described, eighty maggots were thus expelled in four days.

Deutsche medizinische Wochenschrift, Leipzig

50: 665-704 (May 23) 1924

A Protein from Tubercle Bacilli. III. E. Toenniessen.—p. 665.
*Tuberculosis Immunity. R. Arima et al.—p. 666.
*Human and Bovine Tuberculosis. Schilling and Hackenthal.—p. 668.
Ten Years of Treatment of External Tuberculosis. E. Kisch.—p. 668.
*Experimental Tuberculosis and Vitamins. B. Leichtentritt.—p. 672.
*Serodiagnosis of Tuberculosis. G. Blumenthal.—p. 673.
*Wassermann's Tuberculosis Reaction. S. Silberstein.—p. 675.
Fornet's Agglutination Test. L. Kogan.—p. 677.
Tuberculosis and Lead Poisoning. K. Kisskalt and F. Schütz.—p. 678.
*Hemogram in Tuberculosis. H. Dornedden.—p. 678.
Specific Treatment of Tuberculosis. C. Schilling.—p. 681.
Roentgen Treatment of Pulmonary Tuberculosis. E. Baeuchlen.—p. 682.
Stimulation Treatment in Surgical Tuberculosis. E. Rüscher.—p. 684.
Treatment of Cutaneous Tuberculosis. G. Lieschke.—p. 685.
Blood Calcium in Tuberculosis. W. Zimmermann.—p. 686.
Sedimentation Test in Children. R. Wachter.—p. 687.
Contagious Forms of Tuberculosis. A. Winkler.—p. 689.
Telling a Patient About Contagiousness. Kayser-Petersen.—p. 692.
Clinical or Bacteriologic Classification of Cases? P. Schmidt.—p. 693.
Epidemiology of Tuberculosis in Schools. A. Hofmann.—p. 693.
Distress of Lupus Patients. Axmann.—p. 695.
Berlin Information Bureau for Tuberculosis, Alcohol and Cancer Patients. F. Blumenthal.—p. 695.

Tuberculosis Immunity.—Arima, Aoyama and Ohnawa succeeded in getting on saponin-containing mediums tubercle bacilli which were not acid fast. These strains have a low virulence. Rabbits and guinea-pigs were protected by them against subsequent injections of more virulent strains.

Differential Biologic Test of Type of Human and Bovine Tubercle Bacilli.—Schilling and Hackenthal found a marked specificity in the action of extracts from human and bovine tubercle bacilli on the surviving intestine of guinea-pigs infected with tubercle bacilli of the same type.

Experimental Tuberculosis and Vitamins.—Leichtentritt prolonged the life of tuberculous guinea-pigs by feeding them large amounts of neutralized lemon juice. Large doses of cod liver oil (10 c.c. daily) had an unfavorable influence, due to the overdose of fat.

Serodiagnosis of Tuberculosis.—G. Blumenthal extracts tubercle bacilli with acetone, and then with distilled water with addition of phenol. The antigen thus obtained is stable.

Wassermann's Tuberculosis Reaction.—Silberstein tested 375 serums from 334 patients for Wassermann's tuberculosis reaction. The strongest reactions were obtained with serums from nontuberculous syphilitics. He does not consider this reaction nor any other as sufficiently specific for practical purposes.

Hemogram in Tuberculosis.—Dornedden was able to draw correct deductions as to the toxemia and resisting power of tuberculous patients by differential counts (including the younger forms of neutrophils) of blood smears.

Deutsche Zeitschrift für Chirurgie, Leipzig

185: 145-288 (May) 1924

*Tuberculosis of Male Genital Organs. L. Sussig.—p. 145.
*Cancer in Large Intestine. H. Steindl.—p. 186.
*Diagnosis of Acute Necrosis of the Pancreas. K. Bringmann.—p. 211.
*Bone and Joint Tuberculosis. O. H. Petersen and J. Hellmann.—p. 230.
*Intratracheal Thyroid. H. Schachenmann.—p. 248.
*Total Gastrectomy for High Cancer. A. Schüppel.—p. 268.
Spontaneous Dislocation in Tuberculous Coxitis. Münch.—p. 274.
Complication of Fracture of Patella. E. Hertel.—p. 279.
*Roentgenography of Exposed Kidney. K. Reschke.—p. 281.
Transverse Bar in Correcting Foot Deformity. O. Roith.—p. 286.

Genital Tuberculosis in the Male.—Sussig states that in the 83 cases of this kind in Hochenegg's service, 1904 to 1922, rectal examination revealed tuberculous lesions in the prostate or seminal vesicles in two-thirds of the cases, although there had been nothing at any time to indicate disease in these organs. In 23 cases treatment was merely conservative; operative in the others. Recent reexamination in 44 cases showed that one of the 8 conservatively treated patients had recovered completely, the genital process healing and the process in the lung being arrested, the clinical cure persisting for fifteen years to date. A clinical cure was realized also in two other cases, but the tuberculosis continued to progress in the rest. In 85 per cent. of the total 87 cases some tuberculous process elsewhere in the body was manifest; generally it was in the lung, and only in 6 was it in a latent stage. Sussig thinks we can accept it as the rule that genital tuberculosis in the male is always preceded by some tuberculous process elsewhere, and that the process attacks the genital apparatus as a whole, not any one organ. He declares also that involvement of the other side is almost invariably due to blood-borne infection and not to transmission by way of the vas deferens. Sooner or later, in 90 per cent. the previously supposedly healthy testis and epididymis on the other side developed tuberculosis after semicastration. General treatment for tuberculosis is imperative after operation the same as in the conservatively treated cases. The mortality in the purely conservatively treated cases was 37.5 per cent. while it was 50.4 per cent. when treatment was restricted to the operation alone. Combination of conservative and operative measures should be the rule, and it must be borne in mind that the primary process elsewhere—often dating from childhood—is liable to flare up even after many years. In conclusion he warns that neglect of rectal examination in case of pelvic tuberculous processes is a grave fault, as likewise neglect of microscopic examination before labeling any process as tuberculous.

Cancer in Pelvic Large Intestine.—Steindl reports satisfactory outcome in cases of cancer in the rectum treated by drawing the unopened cancer segment outside, in the sacral region, and resecting it a few days later. With extensive progressing gangrene, even this procedure is of no avail. Four of the total twenty patients thus treated died.

Differential Diagnosis of Acute Necrosis of the Pancreas.—Bringmann tabulates the characteristic blood findings in 3 cases. The neutrophils formed 90 to 93 per cent. of the leukocytes, with 2.5 and 3 per cent. lymphocytes, 4.5 to 7.5 per cent. monocytes, and aneosinophilia. The neutrophils showed pronounced shifting of nuclei, of the hyperregeneration type:

0.5 per cent. myelocytes, 8-10.5 per cent. youthful forms; 23 to 29 per cent. rod nuclei and 53 to 60 per cent. segmented nuclei. Blood findings like these are never found in ileus, cholecystitis, kidney colic, acute gastroduodenitis or mesenteric thrombosis—the affections for which acute necrosis of the pancreas is liable to be mistaken. They are found in perforative peritonitis, but this calls likewise for immediate laparotomy.

Roentgen-Ray Treatment of Bone and Joint Tuberculosis.—Analysis of 669 cases confirms that the roentgen rays can be regarded only as an adjuvant, and that small doses are imperative.

Aberrant Thyroid Tissue in the Trachea.—The struma intratrachealis was easily removed from the girl, aged 18. Of the thirty-five similar cases on record, 68 per cent. were in women. In seven cases, the normally located thyroid seemed to have grown into the trachea.

Total Gastrectomy for Cancer.—Schüppel lists his case as the forty-first on record. The cancer in the man, aged 44, was located close to the cardia, and the upper loop of the jejunum was sutured end-to-side to the esophagus stump. After this the duodenum was joined to the jejunum, and the stomach and pylorus region were removed entire. Nourishment was given through a jejunal fistula during the two-hour operation, and recuperation was prompt and apparently complete. The first gastric symptoms had been noted six months before.

Kidney Calculi.—Reschke drew the kidney out in two cases and worked the roentgen plate, wrapped in black paper, in front of or behind the kidney. The patient was then wheeled into the roentgen room. In ten minutes the finished roentgenogram cleared up the diagnosis.

Jahrbuch für Kinderheilkunde, Berlin

104: 321-420 (April) 1924

Chronic Epidemic Encephalitis in Children. J. Grósz and M. Goldberger.—p. 321.
*Cholelithiasis in Children. A. Fischer.—p. 350.
*Infectious Intervertebral Chondritis. A. Báron.—p. 357.
Sinus Thrombosis After Otitis. A. Neubauer.—p. 361.
Roentgen-Ray Treatment of Tuberculosis. A. Weisz.—p. 365.
*Osmotic Resistance of Erythrocytes. D. Acél.—p. 377.
*Tetany Spasms Due to Autonomous Nerves. F. Groszmann.—p. 382.
Paroxysmal Hemoglobinuria in Child. S. Földes.—p. 392.

Cholelithiasis in Children.—Fischer reports the history of a case of cholelithiasis and three cases of cholecystitis in girls from 9 to 11 years of age. One of them had empyema of the gallbladder in the second week of typhoid. One girl, aged 2½, had a partial occlusion of the common bile duct, on the fifth day of scarlet fever, from compression by enlarged lymphatic glands. She was operated on and died. Another, with a staphylococcus cholecystitis, recovered.

Infectious Intervertebral Chondritis.—Báron's patient, a boy, aged 12, suddenly developed symptoms of influenza. Pains in the back were followed by a bending of the spine from which he recovered only slowly. The roentgen-ray examination revealed a probable affection of the intervertebral disks.

Osmotic Resistance of Erythrocytes.—Acél found that the erythrocytes of infants and young children are more resistant to hypotonic solutions than those of adults.

Tetany Spasms Due to Autonomous Nerves.—Groszmann observed roentgenoscopically a contracture of the stomach in an infant, aged 18 months, with latent spasmophilia. The infant recovered after calcium treatment. This medication combined with belladonna gave good results in a 10 months old, artificially fed infant who was taken ill suddenly with signs of ileus. There was a spasm of the sigmoid flexure and a dilatation of the colon.

Klinische Wochenschrift, Berlin

3: 913-960 (May 20) 1924

Constitution and Urology. C. Posner.—p. 913.
*The Vagus Compression Test. G. Recht.—p. 916.
Serodiagnosis of Cancer. H. Kahn.—p. 920.
Endocarditis or Thrombosis of Valves. E. Roesner.—p. 922.
Peroxydases. H. W. Bansi.—p. 927.
*Heredity and Sex of Progeny. J. Bauer.—p. 928.
*Birth Injuries. A. Stern and P. Schwartz.—p. 931.
By-Effect of Phenylcinchoninic Acid. W. Schwahn.—p. 935.
Thyroid and Antibody Production. Weyrauch and Herzfeld.—p. 936.
Light and Protein and Purin Metabolism. H. Wiener.—p. 936.
*Pseudochylous Exudates. W. D. Jankowsky.—p. 937.
Enteroptosis. R. Levy.—p. 938.
*Genesis of Teratomas. M. Budde.—p. 942.

Dyspnea in the Vagus Compression Test.—Recht investigated the changes of respiration occurring after compression of the pneumogastric. He observed in many instances dyspnea with deep respiration, which changed into apnea of short duration after the release from pressure. The disturbance is chiefly reflex, but direct changes in the brain circulation, caused by the simultaneous compression of the carotid artery and jugular vein, may play a part.

Heredity and Sex of Progeny.—Bauer publishes sex statistics in regard to more than 12,000 children from 2,300 families. There was no indication of any predisposition for procreation of either boys or girls.

Injuries to Child at Birth.—Stern and Schwartz deal with the clinical signs of injuries suffered by the baby during birth. A large number of them are due to hemorrhages caused by the difference between the high intra-uterine and low external pressure. Spontaneous nystagmus and the intensity of deformation of the skull were investigated in 100 infants. Nystagmus was present in only one third of the 44 normally delivered infants, but in all of the 11 with faulty presentation. Spontaneous nystagmus was absent only in 4 out of 24 cases of contracted pelvis deliveries, and in 8 out of 69 babies with marked molding of the head. It was present, however, in 18 out of 28 babies with normally shaped skulls. The 3 babies delivered by cesarean section had a round head and no nystagmus. In 4 other cases, the head was already deformed (before rupture of the membranes) and nystagmus was present. Intra partum molding of the cranial bones invariably causes a change in the brain. Many instances of asphyxia, debility and convulsions in the new-born are merely symptoms from cerebral lesions.

Pseudochylous Pleuritic Effusion.—Jankowsky found remnants of larvae of ascarids in a pseudochylous pleuritic exudate.

Genesis of Teratomas.—Budde considers only the external malformations as rudiments of twins. The internal teratomas are real tumors which may have been derived from the original blastophore.

Medizinische Klinik, Berlin

20: 661-696 (May 18) 1924

*Excretory Function of the Liver. T. Brugsch and H. Horsters.—p. 661.
*Phenylcinchoninic Acid in Liver Affections. K. Grunenberg and H. Ullmann.—p. 663.
*Suboccipital Puncture. R. Wartenberg.—p. 665.
*Osteomyelitis of Tenth Dorsal Vertebra. J. Raimann.—p. 670.
Treatment of Axillary Abscesses. A. Rütz.—p. 672.
Ampules for Injection and Aspiration. R. Mühsam.—p. 676.
Treatment of Typhoid. S. Schwarzbart.—p. 677.
Treatment of Furunculosis. H. Ziemann.—p. 677.
*Action of Chimney Gases. J. Stoklasa.—p. 678.
"Peroxydase Reaction." V. Schilling.—p. 679.
Dermatologic Diagnosis. W. Frieboes.—p. 680.
Indications for Roentgen-Ray Treatment. H. Fritsch.—p. 683. Conc'n.—p. 719.
Some Legal Aspects of Practice. F. Thomas.—p. 695. Conc'n.—p. 730.

Excretory Function of the Liver.—Brugsch and Horsters emphasize the excretory function of the liver. A retention of bile produces a real poisoning. They propose to use the name "choleretics" for substances which increase the production of bile, and keep the term "cholagogues" for the drugs which merely promote its expulsion. The biliary acids, insulin (in one experiment) and especially phenylcinchoninic acid are the only drugs with distinct choleretic action known so far.

Phenylcinchoninic Acid in Liver Affections.—Grunenberg and Ullmann had good results with injections of phenylcinchoninic acid in catarrhal jaundice.

Suboccipital Puncture.—Wartenberg describes the technic and possible uses of suboccipital puncture.

Osteomyelitis of Tenth Dorsal Vertebra.—Raimann's patient, a girl, 11 years of age, was taken suddenly ill about four weeks after having had two furuncles. The whole spinal

column was painful, but no local symptoms were present. The child died from pyemia. Necropsy revealed osteomyelitis of the tenth thoracic vertebra, with a prevertebral abscess as probably the oldest lesion.

Action of Chimney Gases.—Stoklasa describes the noxious action of chimney gases on vegetation and animals. Sulphurous acid and sulphur dioxid are the main agents. Coniferae (fir, etc.) cannot thrive in large cities, and the chlorophyl is poisoned also in the country in the neighborhood of coal-burning industries. In every large European city a man takes in, by breathing, every day 25 c.c. (71.5 mg.) of sulphur dioxid. The author asks for legal protection against these gases.

20: 697-732 (May 25) 1924

Antireaction of Nerve Centers and Immune Reactions. Pötzl.—p. 697.
*Baldness. E. Saalfeld.—p. 701.
*Leukorrhea in Virgins. P. Bröse.—p. 703.
*Prolonged Echolalia Stage in Child. A. Pick.—p. 706.
Stenosis of Aorta. H. Gerhartz.—p. 707.
*Sensitization and Eczema. E. Pulay.—p. 708.
*Lecithin and After-Effects of Anesthesia. Birkholz.—p. 709.
*Treatment of Acute Glaucoma. E. A. Heimann.—p. 713.
*Diet in Fever. Weckerling.—p. 714.
Treatment of Chronic Arthritis. Wessel.—p. 714.
*Roentgen Rays and Blood Catalase. J. Magat and J. Rother.—p. 715.
Determination of Blood Sugar. H. Mommsen.—p. 717.
Occupational Lead Poisoning. A. Wilde.—p. 717.
Origin of Syphilis. F. Pinkus.—p. 718.

Baldness and the Sympathetic.—Saalfeld resected one cervical sympathetic in rabbits. The hair grew much more quickly on the ear of the operated side.

Leukorrhea in Virgins.—Bröse found an endometritis as the cause of leukorrhea in forty-three out of forty-seven virgins examined by him during the forty years of his practice. He does not believe in purely constitutional causes. Children's infectious diseases and menstruation are the probable etiologic factors, according to him.

Prolonged Echolalia Stage in Child.—Pick points to the analogies between the various types of aphasia and the arrested development of speech in children. He investigated the outcome in two girls with normal intelligence, whose speech consisted in mere echolalia (described by Schwendt and Wagner in 1899). Both girls have grown up and speak normally.

Sensitization and Eczema.—Pulay describes a case of naphthalin dermatitis in a woman. The itching, infiltration of the skin, eruption at the corners of the mouth and pigmentation around the nails are characteristic.

Lecithin and After-Effects of Anesthesia.—Birkholz is skeptical as to the alleged beneficial action of lecithin on the after-effects of chloroform anesthesia. The doses recommended are—when compared with the body fat—so small that they cannot play any rôle in the adsorption of the anesthetic (Overton's theory).

Treatment of Acute Glaucoma.—In a patient with acute glaucoma, Heimann injected under the conjunctiva 0.2 c.c. of a 0.1 per cent. solution of epinephrin. After forty-eight hours he gave another injection of 0.4 c.c. The patient, who was also being treated with eserin, recovered in a few days.

Diet in Fever.—Weckerling recommends sour milk as the ideal diet in fever.

Roentgen Rays and Blood Catalase.—Magat and Rother found, after roentgen irradiation, an increase in the blood catalase in cachectic patients. Roentgen-ray treatment of the thyroid in toxic goiter lowered the action of the ferment.

Nederlandsch Maandschrift v. Geneeskunde, Leiden

12: 145-184, 1924

*Rickets. J. Haverschmidt.—p. 145.
*Rickets. E. Gorter and J. C. Streng.—p. 173.
*Acute Meningitis and Pyelitis from Colon Bacilli. F. N. Sickenga and J. Munk.—p. 179.

Rickets.—Haverschmidt states that 46.7 per cent. had rickets of the 349 infants less than a year old brought to the dispensary in the fall of 1922: fully 39 per cent. of the 159 breast fed; 56.2 per cent. of the partly artificially fed, and 50 per cent. of the others. In the spring of 1923, the figures were 28.2 per cent. of the 131 breast fed; 75.2 per cent. of those on mixed feeding and 57.8 per cent. of the completely artificially fed. A surprisingly large proportion of the rachitic infants came from new, well lighted and well ventilated homes. His research has confirmed the importance of low phosphorus content of the blood serum, both absolutely, and relatively to the calcium content, for the diagnosis of rickets and the trend of the case. Some endogenous factor seems to pave the way for the vitamin and light deficiency factors to exert their influence. Conditions are more complex than in experimental rickets.

Pathogenesis of Rickets.—The experimental research described has convinced Gorter and Streng that rickets is due to lack of phosphates, either from deficient supply in the food or excessive losses from the organism. The fat soluble vitamin in the food probably regulates the phosphorus metabolism, and its action is weak in the dark, the vitamin requiring sunlight or ultraviolet light to exert its maximal action. Certain other catalyzers also are photosensitive. They present this theory as a working hypothesis, saying that the vitamin with these peculiar properties deserves a place apart, as Vitamin D. We must give cod liver oil more freely to infants and insist on their getting outdoors more in winter. They declare that it may soon be the routine practice to give every infant one or two teaspoonfuls of cod liver oil from the fourth month on, and suggest that the less purified oil may prove the best. They warn further that sunlight passing through a window pane loses almost all its efficacy in treatment of rickets.

Colon Bacilli Meningitis and Pyelitis.—The infant with meningitis died and pus was found in the ventricles. Colon bacilli had been cultivated from the lumbar puncture fluid during life, and a bacteriophage active against the colon bacilli from this fluid and the stools. Treatment had been with hexamethylenamin and a bacteriophage, but without avail. To facilitate puncture of the ventricle the cuff of the blood pressure apparatus was applied to compress the skull, which proved a valuable aid. The twenty-first day 0.5 c.c. of the bacteriophage in saline solution was injected into the ventricle, and the fluid in it a week later was transparent, yellowish, and only a few colon bacilli could be cultivated from it. The effect was transient, however, and the disease progressed to a fatal termination the tenth week. The infection probably dated from the first week of life; in six other cases the colon bacillus infection took the form of pyelitis. In one case it was certainly of blood-borne origin. The infant was less than three months old, and recovered under treatment with an autogenous vaccine and sodium lactate (3 gm. daily). The p_H of the urine changed from 5.5 to 8. No bacteriophage was found. The infant has been thriving since although colon bacilli were still found in the urine seven months later.

12: 185-238, 1924

A Case of Malta Fever in the Netherlands. L. P. Daniels et al.—p. 185.
*Insulin Treatment of Diabetic Coma. J. Doijer.—p. 195.
*Stain Test of Stomach Function. J. Koopman.—p. 215.
"Horse Infectious Anemia" in Man. J. T. Peters.—p. 222.
*Syphilitic Dermatitis Plus Liver Disease. P. H. Kramer.—p. 232.

Diabetic Coma.—Doijer was impressed with the prompt success of insulin treatment in a recent series of nine cases of diabetic coma or precoma.

Stain Test of Stomach Function.—Koopman's tables show the interval before the appearance of the stain in the duodenal tube after intramuscular injection of 4 c.c. of a 1 per cent. solution of neutral red. In eight cases of pernicious anemia and several of cancer or chronic gastritis, the interval was from forty to sixty minutes. In five cases of gastric neurosis or ptosis, from fourteen to seventeen minutes, but in ten with gastric ulcer or neurosis, all with hyperchlorhydria, the intervals ranged from four and a half to twelve minutes.

Syphilitic Skin and Liver Process.—The man of 42 had been under treatment by a quack for three years for an extensive dermatosis on the neck and region just below, with numerous fistulas. Then the abdomen suddenly began to enlarge. After withdrawal of 6 liters of ascitic fluid and systematic treatment for syphilis, the whole clinical picture subsided. The severe and progressive skin affection might be entitled, "The Consequences of Three Years of Quack Treatment." This allowed the syphilitic cirrhosis of liver and spleen time to become installed.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JANUARY-JUNE, 1924

The following journals have been reviewed and abstracts of important articles made in the Current Literature Department of THE JOURNAL during the past six months. Any of the journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Two journals may be borrowed at a time. No foreign journals are available prior to 1920, nor domestic journals prior to 1923. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Thus most of the journals indexed are accessible to the general practitioner, no matter where located.

A. M. M. Asociación Médica Mexicana. M. Mexico City.
Acta Chirurgica Scandinavica. Irregular. 20 kronor. Stockholm.
Acta Dermatologica. Irreg. Kyoto, Japan.
Acta Medica Scandinavica. Irregular. 20 kronor. Stockholm.
Acta Ophthalmologica. Irreg. $6 per volume. Copenhagen.
Acta Pediatrica. Irregular. $5 per volume. Upsala.
Acta Scholae Medicinalis Universitatis Imperialis in Kioto. Irregular. 3.30 yen per issue. Kioto.
American Journal of Anatomy. Bi-m. $7.50 per volume. 36th St. and Woodland Ave., Philadelphia.
American Journal of Diseases of Children. M. $4. American Medical Association, 535 N. Dearborn St., Chicago.
American Journal of Hygiene. Bi-m. $6. 310-312 W. Monument St., Baltimore.
American Journal of the Medical Sciences. M. $6. Lea & Febiger, 706 Sansom St., Philadelphia.
American Journal of Obstetrics and Gynecology. M. $6. C. V. Mosby Co., St. Louis.
American Journal of Ophthalmology. M. $10. 7 W. Madison St., Chicago.
American Journal of Physiology. M. $5 per volume. 19 W. Chase St., Baltimore.
American Journal of Psychiatry. Q. $5 per volume. Johns Hopkins Press, Baltimore.
American Journal of Public Health. M. $5. 370 Seventh Ave., New York.
American Journal of Roentgenology and Radium Therapy. M. $10. Paul B. Hoeber, 67 E. 59th St., New York.
American Journal of Syphilis. Q. $7. C. V. Mosby Co., St. Louis.
American Journal of Tropical Medicine. Bi-m. $5 per volume. Williams & Wilkins Co., Baltimore.
American Review of Tuberculosis. M. $4 per volume. National Tuberculosis Association, 370 Seventh Ave., New York.
Anales de la Facultad de Medicina, Universidad de Lima. Bi-m. 1.50 soles per issue. Lima, Peru.
Anales de la Facultad de Medicina, Universidad de Montevideo. M. 6 pesos per year. Montevideo.
Anales de la Sociedad Medico-Quirúrgica del Guayas. M., excepting February and March. $6. Guayaquil, Ecuador.
Annales de l'Institut Pasteur. M. 55 francs. Paris.
Annales des Maladies Vénériennes. M. 52 francs. Paris.
Annales de Médecine. M. 55 francs. Paris.
Annali d'Igiene. M. 60 lire. Rome.
Annali Italiani di Chirurgia. M. 70 lire. Naples.
Annals of Clinical Medicine. Bi-m. $6. Williams & Wilkins Co., Baltimore.
Annals of Medical History. Q. $8. Paul B. Hoeber, 67 E. 59th St., New York.
Annals of Otology, Rhinology and Laryngology. Q. $6. 5154 Westminster Place, St. Louis.
Annals of Surgery. M. $10. J. B. Lippincott Co., E. Washington Square, Philadelphia.
Annals of Tropical Medicine and Parasitology. Irregular. £1 2s. 6d per volume. Liverpool.
Archiv für Dermatologie und Syphilis. Irreg. Price varies. Berlin.
Archiv für Gynäkologie. Irregular. Price varies. Berlin.
Archiv für Kinderheilkunde. Irregular. 21 Swiss francs per volume. Stuttgart.
Archiv für Klinische Chirurgie. Irregular. Price varies. Berlin.
Archiv für Verdauungs-Krankheiten. Irregular. 25 Swiss francs per volume. Berlin.
Archives of Dermatology and Syphilology. M. $6. American Medical Association, 535 N. Dearborn St., Chicago.
Archives of Diagnosis. Q. $3. Rebman Co., 141 W. 36th St., New York.
Archives Franco-Belges de Chirurgie. M. 60 francs. Brussels.
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This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths" and "Society Proceedings" are indexed under these titles at the end of the letters "B," "D" and "S." State board examinations are entered under the general heading State Board Reports, and not under the names of the individual states. Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

For author index see page 2195.

A

ABDERHALDEN REACTION, [Högler & Serio] 1486—ab
serologic split products, [Lüttge & Mertz] 2000—ab
ABDOMEN, abdominal pressure and heart action, [Petényi] 427—ab
acute, hyperesthesia with, [Cope] 824—ab
acute, in children, [Helmholz] 1397—ab
Adhesions: See under Adhesions
contusions of, [Audain] 928—ab
drainage of peritoneal cavity, [Schönbauer] 1903—ab
examination, use of laparoscopy, [Zollikofer] 1403—ab
foreign body in, responsibility of surgeon in leaving compress in, 1706
injuries, influence of hemorrhage on mortality in, [Mason] 1393—ab
injuries, macular erythema following, [Rasch] 1994—ab
lesions in region below liver, [Lacouture & Damade] 67—ab
pain in, interpretation of, [Kramer] *604
surgery, preventive, [Roberts] 1810—ab
ulcer of abdominal wall following drainage, [Cullen] 2146—ab
ABNORMALITIES: See also under names of organs and regions
ABNORMALITIES, anatomic, [Harrower] 1003—ab
ABORTION and hard times, [Bumm] 345—ab
and mercury poisoning, 1286
conflict with forensic experts, 141
criminal, [Wyder] 1997—ab
criminal, campaign to prevent, [Wyder] 2000—ab
criminal, no rights of action between woman and abortionist, 653—Ml
criminal, repression of, [Hirsch] *1310—ab
febrile, treatment of, [Winter] 427—ab, [Grabich] 588—ab, [Laemmle] 1235—ab
imminent, from overfilled bladder, [Borger] 1235—ab
incomplete, expectant treatment of, [Bovin] 590—ab
production of criminal miscarriage, manslaughter, 1806—Ml
treatment of, [Ludwich] 73—ab, [Hillis] 658—ab, [Gordon] *1021
tubal, [Lejars] 1481—ab
ABRAMS TREATMENT, certain electrical diagnostic and therapeutic methods from standpoint of a neuro-psychiatrist, [Pinkham] 147—C
electronic reactions of Abrams, 1208
ABSCESS: See also under names of organs and regions
ABSCESS, cold abscesses in thorax wall, [de Waard] 254—ab
gravity, of chest cavity, [Sick] 930—ab, [Chaoul & Lange] 1825—ab
ossifluent, routes of migration of, [Vacchelli] 594—ab
pelvic, acute, in children, [Rosenblum & Bettman] 1473—ab
perinephritic, mercurochrome for, [Young] 747—ab
ACACIA, effect of gum solution and transfusion on brain, [Crile & others] 1225—ab
ACCADEMIA LEONARDO DA VINCI, 225
ACCIDENTS, accidental injuries caused supposedly by a dentist, 1623
Chicago accident death rate, 1123—ab
effect of working in heat and cold not accidental, 1222—Ml
in London streets, 643
ACETALDEHYD in metabolism, [Gottschalk] 1902—ab
ACETONE, qualitative test for, [Bigwood & Ladd] 243—ab
ACHYLIA GASTRICA, pancreatic function in, [McClure & others] 1146—ab
relation of, to spinal sclerosis, [Vanderhoof] 417—ab
ACID, acetylsalicylic, effect of, on heart, [Mendenhall & Camp] 1078—ab
ACID, acetylsalicylic, reaction of sodium bicarbonate and, 1715
Amino: See Amino-Acids
boracic, acute poisoning from, [Bazin] 2082—ab
chondroitin-sulphuric, in serum, [Dresel] 502—ab
effect of acids and bases on blood cells, [Bostrom] 496—ab
fuchsin sulphurous, 228
hippuric, formation of, 550—E
hippuric, in nephritis, [Snapper & Grünbaum] 665—ab
hippuric, metabolism, [Snapper] 665—ab, [Hofer] 1406—ab
Intoxication: See Acidosis
lactic, alleged rôle of, in arthritis, [Pemberton & others] 1988—ab
lactic, concentration of, in blood, [Anrep & Cannan] 661—ab
Uric: See Uric Acid
ACID BASE EQUILIBRIUM, alterations of tissue alkalinity, [Haldane] 1302—ab
acid alkali balance at high altitudes, [György] 1997—ab
base balance in body, 1125—E
ketogenic-antiketogenic ratio, 2138
regulation of neutrality in children, [Bisgaard & Askgaard] 508—ab
ACIDOSIS and infection, 569
in children, surgical treatment of recurring attacks of, [McGuire] 235—ab
insulin in case of, following trauma, [Ginsberg] *1517
insulin in preoperative and postoperative nondiabetic acidosis, [Fisher & Snell] *699
ketosis and insulin, 1695—E
organic and inorganic, [Beumer & Soecknick] 1234—ab
ACNE due to milk allergy, [Hoge] *788
chronic malaria cause of, [Murray] 2145—ab
treatment of, [Scott] 924—ab, correction, 1792
Vaccine, 967
Vaccine Combined, 1047
ACONITOL, Dorman insulin [Zuelzer] 252—ab
ACRIFLAVINE, internal use of, in urinary infections, [Davis] 999—ab
intravenous injections of, in gonorrhea, [Jacob & Verasingam] 1151—ab
intravenous injections of, effects of, [Spencer] 1226—ab
ACRODYNIA, erythredema polyneuritica, [Paterson & Greenfield] 66—ab, [Braithwaite & Pegge] 1301—ab
ACROMEGALY, protein metabolism in, [Thannhauser & Curtius] 1086—ab
ACTINOMYCOSIS appendicitis, [Kaplan] 1086—ab
primary, of kidney, [Abbott] *1414
ADAMS-STOKES' SYNDROME: See Heart block
ADDISON'S DISEASE, clinical studies in, [Rowntree] 1886—ab
ADENOIDS, Schick test in children with, [Traina] 341—ab
the adenoid child, [Wills & Warwick] 825—ab
ADHESIONS, abdominal, disturbances from adhesions between gallbladder and duodenum, [Schneider] 1009—ab
arm-chest, treatment of, [Davis] 822—ab
pericecal and pericolic, [Echeverri Marulanda] 250—ab
Pleural: See under Pleura
ADHESIVE TAPE, sensitivity to, 2070
ADIPOSIS DOLOROSA due to diencephalic disorders, [Waldorp] 1078—ab
in 300 B. C., [Crummer] *1420
ADNEXA: See Uterus, adnexa
ADOPTION, National Adoption Society, 483
ADRENALIN: See Epinephrin
ADRENALS: See Suprarenals
ADULTERY, what is law for man is also law for woman, 154—Ml
ADVERTISING, misuse of prophylactic propaganda, 1706
AEROPHAGY, 1458
AGAR: See Bacteria culture media
AGGLUTINATION and erythrocytes, [Isaacs] 1076—ab
AGGLUTINATION, prozone in, [Chiari & Löffler] 1743—ab
venesection and immunity, [Fragomele] 425—ab
AGGLUTININS: See also Iso-Agglutinins
AGGLUTININS, typhoid, productions of, [Guyer & Smith] 244—ab
AIR, alveolar, carbon dioxid in, [Porges] 930—ab
concussion, physiologic effects of, [Hooker] 495—ab, 1446—E
rebreathed, sensitization to, 471—E
ALASTRIM and smallpox, blood in, [Sabrazes & Massias] 239—ab
is mild smallpox, [Hill] 747—ab
ALBUMINS, distribution of globulins and, [Gutzeit] 664—ab
ALBUMINURIA, test for, [Groll] 170—ab
orthostatic, treatment of, [Ramond] 1737—ab
significance of, 1715
with tonsillitis, [Jones] 1650—ab
ALCOHOL: See also under Prohibition
ALCOHOL and germ plasm, 1444—E
and human body, 1374
denatured, canned heat as beverage, 1139, 1383
effect of, on blood sugar, [Blatherwick & others] 496—ab
effect of, on patellar tendon reflex, [Tuttle] 1893—ab
factor of, in eliminating racial degeneracy, [Stockard] 1727—ab
industrial users protest Crampton bill, 1055
liquor consumption in United States, 1371
nonbeverage, tax on, 312
pharmacopeial standards for medicinal spirits, 481
restriction of, and cirrhosis of liver, 117—ab
validity of restrictions on prescribing, 57—Ml
Wood: See Methyl Alcohol
ALCOHOLISM, acute, blood and spinal fluid in, [Finlayson & Karnosh] 922—ab
and cheap lodging houses, 807
and tuberculosis, [Samson] 2091—ab
campaign against tuberculosis and, 1210
during and since the war, 1061
eye disturbances in, [Runge] 1484—ab
mental states in, [Pierce] 1820—ab
ALEXANDER, GUSTAV, 50th birthday of, 645
ALIENIST, distinguished, when one may testify as to observations—testimony of, 1142—Ml
questions and cross-examination for one not alienist, 154—Ml
ALIMENTARY TRACT: See Gastro-Intestinal Tract
ALKALIS, effect of, on blood cells, [Bostrom] 496—ab
ALKALOSIS and tetany, [Adlersberg & Porges] 168—ab
clinical conditions of, [Kast & others] *1858
in gastric disease, [Youmans & Greene] 1570—ab
sodium poisoning, tetany and alkalosis, [Greenwald] 1224—ab
ALKAPTONURIA, [Vöhtz] 1488—ab, [Young] 2147—ab
ALLERGENS, preparation of, 991
ALLERGY: See Anaphylaxis
ALLONAL-ROCHE, 1066
ALOPECIA, cause of, [Stein] 589—ab
and the sympathetic, [Saalfeld] 2150—ab
in children, after roentgenray treatment of ringworm, 1209
treatment of, 1462
ALTERNARIA, unusual organism (Alternaria, sp.) occurring in chronic pulmonary disease; preliminary note, [Wahl & Haden] *1924
ALTITUDE and red blood corpuscles, 720—E
causes of mountain sickness, 1794
high, acid-alkali balance at, [György] 1997—ab
high, blood at, [Knoll] 928—ab
high, blood volume at, [Laquer] 588—ab
maximum respiratory output, [Izquierdo] 1901—ab
relation of malaria to, [Gill] 162—ab
AMBLYOPIA, tobacco, [Adrogué] 69—ab
toxic, [de Andrade] 166—ab, [Terrien] 927—ab

"AMBOCEPTOR," dry, [Hirsch & LeCount] 498—ab
AMBULANCE, air service ambulance, 1792
AMEBIASIS: See also Dysentery, amebic
AMEBIASIS and emetin, 1782—E
bronchopulmonary, amebic bronchitis, [Peizetakis] 1734—ab
familial, [Panayotatou] 1653—ab
peculiar variety of intestinal ameba, [Lynch] 918—ab
AMENORRHEA, constitutional aspects of, [Aschner] 429—ab
AMERICAN MEDICAL ASSOCIATION, alumni associations and fraternities, Chicago session, 1536
annual congress on medical education, medical licensure, public health and hospitals, 307—E, 798, 890, 972
annual presentation by Council on Medical Education and Hospitals, of results of state board examinations, 1343
auditor's report, 1950
Board of Trustees, minutes of annual meeting, 475
Board of Trustees, report of, 1941, 1949, 2034, 2037
Bureau of Health and Public Instruction of, work of, [Dodson] 975—ab
Chicago hotels, 1536
Chicago session, 214, 396, 474, 722, 1051, 1271, 1367, 1448, 1522, 1615, 1697, 1786, 1868, 1876—E, 2055—E
clinics at Chicago Municipal Sanitarium, 1868
commercial exhibit, 1550
Committee for Study of Toxic Effects of Local Anesthetics, statement by [Mayer] *876
conference on legislative program and procedure, 1448
conflict of annual sessions with final exercises of medical colleges, 1966
diagnostic clinics, Chicago session, 1534
election of officers, 2033
entertainment at Chicago session, 1534
foreign guests at Chicago session, 1534
Golfing Association, 1448, 1786
hospital service in United States; third presentation of hospital data by Council on Medical Education and Hospitals, *118
House of Delegates, address of President-Elect Pusey; trend in medical and nursing services, 1960
House of Delegates, address of President Wilbur, 1968
House of Delegates, address of speaker, Dr. Warnshuis, 1959
House of Delegates, meetings, 1938, 1959, 2033
House of Delegates; preliminary roster of, 1522
interns of Chicago hospitals to attend meetings, 1697
meeting on anesthesia, 2050
meeting on radiology, 2050
meeting places and general headquarters at Chicago session, 1537
motion picture theater, 1540, 2051
motor coach tours after Chicago session, 1615
nonaffiliated organizations meeting during Chicago session, 1538
official call to officers, fellows and members, 1522
opening of general meeting, 1973
place of 1925 Annual Session, 2033
preliminary program of scientific assembly, 1541
president's address; some of the social problems of medicine, [Pusey] *1905
president-elect, 2055—E
program of Woman's Auxiliary, 1868
proposed amendment to By-Laws, 2037
reference committees, 1964
registration for Chicago session, 1531, 2051
report of Committee from Section on Laryngology, Otology and Rhinology on otolaryngic hygiene of meeting, 1966
report of Committee of Miscellaneous Business, 1969
report of Committee of the Whole, 1970
report of Committee on Amendments to Constitution, 1967
report of Committee on Awards, 2051
report of Committee on Legislation and Public Relations, 1967, 2035
report of Committee on Reapportionment of Delegates, 2034
report of Committee on Reports of Officers, 1969
report of Committee on Rules and Order of Business, 2034
report of Committee on Sections and Section Work, 1969
report of Council on Medical Education and Hospitals, 1952
report of Council on Scientific Assembly, 1959
report of Judicial Council, 1951, 2035
report of Reference Committee on Amendments to the Constitution and By-Laws, 1973
report of Reference Committee on Hygiene and Public Health, 1970, 2035, 2036
report of Reference Committee on Medical Education and Hospitals, 1969, 2034
report of Reference Committee on Miscellaneous Business, 2036
AMERICAN MEDICAL ASSOCIATION, report of Reference Committee on reports of Board of Trustees and Secretary, 1971
report of Secretary, 1938
report on traumatic and industrial hernia, 1967
resolution from Section on Preventive and Industrial Medicine and Public Health, 2037
resolution on cosmetics, 1966
resolution on dissociating editorship and general management, 1966
resolution on education of young men and women for practice of medicine, 1967
resolution on interchange of official delegates with Canadian Medical Association, 1965
resolution on lack of uniformity in reporting deaths in puerperal state, 1966
resolution on National Prohibition Act, 1966
resolution on proposed amendment to By-Laws, 1965
resolution on questions of ethics and propriety concerning institutional publicity, 1966
resolution on Radiological Section of American Medical Association, 1965
resolution on repeal of certain sections of National Prohibition Act, 1967
resolution on rules with reference to prescribing liquor, 1967
resolution on trachoma work among Indians, 2036
resolution on work of William Whitford, 1967
Scientific Exhibit, 132, 1538, 2051
Section on Dermatology and Syphilology, 2045
Section on Diseases of Children, 2042
Section on Gastro-Enterology and Proctology, 2049
Section on Laryngology, Otology and Rhinology, 2041
Section on Miscellaneous Topics, 2050
Section on Nervous and Mental Diseases, 2045
Section on Obstetrics, Gynecology and Abdominal Surgery, 2038
Section on Ophthalmology, 2039
Section on Orthopedic Surgery, 2048
Section on Pathology and Physiology, 2043
Section on Pharmacology and Therapeutics, 2043
Section on Practice of Medicine, 2037
Section on Preventive and Industrial Medicine and Public Health, 2046
Section on Stomatology, 2044
Section on Surgery, General and Abdominal, 2038
Section on Urology, 2047
significant features of coming session, 1523
supplementary report of Reference Committee on Reports of Officers, 2036
testimonial dinner to Dr. George H. Simmons, 1979
"that orange colored slip" again, 210—E
treasurer's report, 1950
Woman's Auxiliary of, 1367
AMINO-ACIDS, sulphur containing amino-acid, [Mueller] 578—ab
essential, 2053—E
in blood: See under Blood
in fever, [Donath & Heilig] 2092—ab
nephropathic effect of, [Newburgh & Marsh] 1990—ab
vasomotor action of, [Brouha] 1481—ab
AMMONIA, excretion of nitrogen and, [Hubbard] 926—ab
AMMONIUM FLUID, uric acid content of, [Williams & Bargen] 1728—ab
AMPUTATION, gripper, of forearm, [Ceballos] 186—ab
sleeve amputation of thigh, [Wheeler] 162—ab
stump joint amputation stump, [Lehmann] 1574—ab
stumps, painful, [Leriche] 585—ab
AMYL ACETATE, "banana oil" as irritant, 740
AMYLOID, [Kuczynski] 343—ab
ANALGESIA: See Anesthesia
ANAPHYLAXIS: See also under Asthma; Hayfever
ANAPHYLAXIS, [Schmidt & Barth] 252—ab
anaphylaxis to azoproteins, [Landsteiner] 1992—ab
basis of allergic phenomena, [Hanzlik] *2001
blood changes in, [Dean & Webb] 824—ab
calcium therapy of, [Pottenger] 156—ab
dilatation of capillaries and shock, [Ebbecke] 71—ab
duration of, [Zolog] 926—ab
fatal, following hemoplastin, [DeLee] 1564—C
fatal, following intravenous injection of antimeningococcic serum, [Mendeloff] *1862
hepatic anaphylotoxin in, [Manwaring & others] *1504
in guinea-pigs, [Schmidt] 1084—ab
influence of, in production of bronchial catarrh, pulmonary sclerosis and emphysema, [Feuillié] 164—ab
mechanism of leukopenia in, [Webb] 824—ab
morbid anatomy of, [Dean & Webb] 824—ab
passive pulmonary sensitization; its bearing on origin of antibodies, [Manwaring & others] *1104
pharmacodynamic tests for, [Vallery-Radot & others] 425—ab
prevention of, by purifying antiserum, [Besredka] 339—ab
primary specific allergy, [Kämmerer] 1827—ab
quantitative study of anaphylactic capillary permeability, [Manwaring & others] *542
ANAPHYLAXIS, relation of anaphylactic disturbances to arthritis, [Turnbull] *1757
severe delayed anaphylaxis, [Gurd] 577—ab
sudden death after injection of foreign substances, [Lamson] *1091
treatment of hay-fever, asthma and other allergic conditions, [Duke] 59—ab
treatment, prevention of constitutional reactions in desensitization therapy, [Baetjer] 1888—ab
ANATOMY, instruction in, in France and United States, 984
ANEMIA, classification of, [Waugh] 1146—ab
from pregnancy intoxication, [Schneider] 1742—ab
germanium dioxid in, [Schmitz] 1297—ab
hemorrhage and behavior of blood vessels after application of an Esmarch bandage, [Bier] 757—ab
in infancy, [Denzer & Merritt] 1473—ab, [Boyd] 1646—ab
in infants, diet in, [Hoobler] 1570—ab
in infants, urobilin excretion in, [Bass & others] 2078—ab
in new-born, [Donnally] 1473—ab
infectious horse anemia in man, [Peters] 928—ab
pernicious, achlorhydria in, [Hurst] 248—ab
pernicious, and iron, 971—E
pernicious, and small intestine, [Seyderhelm] 1740—ab
pernicious, and spinal cord degeneration, [Hurst] 823—ab
pernicious, and sprue, [Bramwell] 1228—ab
pernicious, as cause of mental disturbance, [Woltman] 1075—ab
pernicious, clinical data of, [Willson & Evans] 1147—ab
pernicious, differential point in, [Piney] 1081—ab
pernicious, disturbed renal function in, [Stieglitz] 655—ab
pernicious, how can we best treat pernicious anemia? [Warfield] 1642—ab
pernicious, of pregnancy, [Aubertin] 585—ab
pernicious or hemolytic anemia of pregnancy, [Rowland] *372
pernicious, phagocytosis of erythrocytes in, [Peabody & Broun] *963, 2078—ab
pernicious, radium treatment of, [Tománek] 1660—ab
pernicious, relationship of hemolytic disorders to, [Panton & others] 1302—ab
pernicious, surgical treatment of, [Walterhöfer & Schramm] 1744—ab
pernicious, treatment of, [Winterfeld] 1156—ab, [Hicks & Jagic] 1743—ab
sickle cell, [Sydenstricker] 1398—ab
splenic, infantile, [Ramsay] 1895—ab
splenic, nature of, [Escudero] 754—ab
splenic, splenectomy in, [Boland] 236—ab
temporary, affects of, on blood vessels, [Bulatao & others] 997—ab
treatment of, 491, [Normet] 502—ab
treatment with iron, [Williamson] 1887—ab
treatment with red bone marrow and spleen, [Leake & Evans] 823—ab
ANESTHESIA, apparatus, possible infection from, 1715
blood pressure during, [Brown] 1003—ab, [Long] 1217—C, [Coburn] *1748
by iontophoresis, [Wirz] 1743—ab
chloroform, for children, [Koello] 663—ab
chloroform, lecithin and after-effects of anesthesia, [Lichholz] 2150—ab
chloroform, surprises of, [Cheinisse] 164—ab
chloroform, tardy injuries from, [Vorschütz] 829—ab
cocain and its substitutes, 414—ME
cocain, surface anesthesia with, [Cohse] 1657—ab
effect of posture on relaxation under, [Palmer] 746—ab
epidural, [Mocquot] 1084—ab, [Barros Lima & others] 1909—ab
ether and chloroform, [Ide] 1303—ab
ether, and glucose injections, [Kutscha-Lissberg] 830—ab
ether, explosion in operating theater, 1794
ethylene, [Papin & Ambard] 1083—ab
ethylene and oxygen as an anesthetic for infants, [Lundy] *448
ethylene, blood reaction in nitrous oxid anesthesia and, [Leake & Hertzman] *1162
ethylene, dangers of, [Luckhardt] *1662
ethylene, in genito-urinary surgery, [Luckhardt & Kretschmer] 1732—ab
ethylene, explosibility of, [Brown] *1039, [Davis] *1607
ethylene for anesthesia, 1609
evidence in case of death under, 1566—MI
explosion in operating theater, 1794
general, prevention of syncope in, [Strube] 588—ab
injury to patient from explosion of machine used in, 329—MI
intraspinal, dangers of, [Rychlik] 1010—ab
intraspinal, retention of urine after, [di Pace] 425—ab
intravenous, for experimental research, [Soler & others] 504—ab
local, in treating abdominal sepsis, [Farr] 1145—ab

ANESTHESIA, local, of mucous membranes, poisoning from, [Wieland & Saito] 1155—ab
local, prostatectomy under, [Jones] 1732—ab
local, toxic effects following use of; analysis of reports of 43 deaths submitted to Committee for Study of Toxic Effects of Local Anesthetics, [Mayer] *876
local, toxicity of, [Meeker & Frazer] 656—ab
mask, modification of, [Green] *1517
nitrous oxid, blood reaction in ethylene and, [Leake & Hertzman] *1162
paravertebral, kidney operations under, [Lowsley & Pugh] *1011
prophylaxis of postnarcotic disturbances, [Nürnberger] 1085—ab
rectal, ether-oil anesthesia, [Dolshansky] 1658—ab
rectal, complication of, [von Zalka] 2090—ab
splanchnic, blocking splanchnic nerves, [Bachlechner] 1157—ab
splanchnic, new instrument in, [Burke] *790
ANEURYSM, aortic, diagnosis of, [Ganter] 831—ab
aortic, and syndrome of sympathetic chain, [André-Thomas] 1737—ab
aortic, rupturing into pulmonary artery, [Scott] *1417
arteriovenous, with fistula, [Hoover & Beams] 655—ab
gluteal, myocotic, [Benjamin & Lachman] *1861
Matas operation for, [Gessner] 1393—ab
of renal artery, [Conroy] 241—ab
of thoracic aorta, [Benjamin & Wiedemer] 420—ab
pulmonary, aneurysmal dilatation of pulmonary artery with patent ductus arteriosus; death from aneurysm into pericardial sac, [Moench] *1672
traumatic arteriovenous, of neck, [Mooro] 162—ab
ANGINA, pustulous, [Marfan] 1230—ab
Vincent's, and etiologic treatment, [Puig] 1997—ab
ANGINA PECTORIS and surgical conditions of abdomen, [Willius] 1645—ab
judicial notice not taken of, 1466—M
prognosis in, [Hay] 65—ab, [Arrillaga] 1824—ab
surgical treatment of, [Odermatt] 71—ab, [Jonnesco] 1083—ab
sympathectomy in, [Kobler & Weth] 1090—ab, [Halstead & Christopher] *1661, [Glaser] 1741—ab, [Henry] 1995—ab
treatment of, [Kappis] 506—ab, [Wenckebach] 2147—ab
treatment of, with benzyl benzoate, [Babcock] 193
ANGIOMAS, collodion treatment of, [Krüger] 507—ab
atavism in hereditary hemorrhagic telangiectasia, [Fitz-Hugh] 495—ab
heredity in origin of nevus, [Siemens] 1814—ab
radium therapy for nevi, [MacKay] 2081—ab
radium therapy of vascular nevi, [Morrow & Taussig] 240—ab
ANGIOSPASM, cerebral, [Finesilver] *1608, 2069—C, [Holmes] 1801—C
atropin for diagnosis and treatment of disturbances from vascular spasm, [Abadie] 1899—ab
ANIMAL EXPERIMENTATION, another dog's protection bill rejected, 1278
bequests for hindrance of medical research, 1447
diabetic patient and his dog, 1502—ab
ANISOCORIA in pulmonary tuberculosis, [Alterthum] 1232—ab
ANKLE, old fractures of, [Geist] *960
nonoperative treatment for bimalleolar fracture, [Savariaud] 1997—ab
ANKYLOSTOMIASIS: See Uncinariasis
ANOXEMIA: See Blood oxygen
ANTHELMINTICS: See under Carbon tetrachlorid; Niyonlyogan; Santonin; Thymol; etc.
ANTHRAX bacilli in feces, [Holman & Fernish] 155—ab
immunity, [Kraus] 1308—ab
infection by lungs, [Brocq-Rousseu & Urbain] 826—ab
treatment of, [Grasser] 1309—ab
ANTHROPOLOGY, course in, 807
prehistoric Netherlanders, 1459
present status of, [Kleiweg de Zwaan & others] 1158—ab
ANTHROPOMETRY, applied, [Gray & Walker] *628
clinical studies in human constitution, [Draper & others] *431
facial characteristics of gallbladder, ulcer, tuberculosis, pernicious anemia and nephritic hypertension patients, [Draper & Dunn] 1989—ab
height and weight of school children, 1798
the narrowing British face, 1704
ANTIBODIES, formation of, [Kabrhel & Kredba] 1090—ab
parsive pulmonary sensitization; its bearing on origin of antibodies, [Manwaring & others] *1104
ANTIBODIES, production, chemical stimulation of, [McIntosh & Kingsbury] 1801—ab
production, rôle of omentum in, [Portis] 1078—ab
ANTIDIPHTHERIC SERUM in ocular infection, [Key] *183
ANTIPNEUMOCOCCIC SERUM, Types I, II, and III and Polyvalent, 1138—P
ANTIPYRIN, inherited idiosyncrasy to, [Freuchen] 1904—ab
ANTISEPTICS, organic binding of, [van Herwerden] 1744—ab
recent progress in germicides and, [Young] 236—ab
urinary, [Young] 999—ab
ANTISERUM: See under Serum; Tetanus antitoxin; etc.
ANTITOXIN: See under Diphtheria; Tetanus; etc.
ANURIA: See Urine, suppression
AORTA, dilatation of, result of high blood pressure, [Sheldon] 750—ab
sclerosis, lipoid spots in intima of, [Westenhöfer] 2093—ab
stomach disturbances from unsuspected disease of, [Monge] 341—ab
AORTIC INSUFFICIENCY, [Barbosa] 753—ab, 1823—ab
bath treatment in, [Lurz] 1658—ab
myocardiac, [Barbosa] 1403—ab
AORTITIS, [Libensky] 346—ab
masked and mild, [Leconte] 1736—ab
syphilis of central nervous system and of aorta, [Löwenberg] 1658—ab
syphilitic, [Willius & Barnes] 1649—ab, [Scott] 1807—ab
APHASIA and apraxia, [Bailey] 1814—ab
APOPLEXY: See also Brain hemorrhage
"APOPLEXY," correct defunction of, [Wells] 1981—ab
APOTHESINE, 793
APPARATUS: See also under Instruments
APPARATUS, movable frame for protecting delirious patients, [Reasoner] *1691
device to hold suspension tackle on jamb of door, [Robinson] *1935
APPENDECTOMY, cutting ileocecal fold in, [Chandler] 1143—ab
APPENDICITIS, abscess after, [Nather] 931—ab
actinomycosis, [Kaplan] 1086—ab
acute, in children, [Muller & Ravdin] *1852
acute, in early pyelophlebitis, [Thalhimer] 1224—ab
and corn-flower seeds, [Eick] 1485—ab
and oxyuris, [Fischer] 829—ab
chronic, [Kuttner] 1826—ab
chronic, simulating pulmonary tuberculosis, [Torres] 1554—ab
diagnosis of, [König] 2092—ab
endemic, [Fonio] 165—ab
false, differentiation of, [Galán] 1085—ab
from foreign bodies, [Berger] 1997—ab
gram-positive anaerobes in, and its complications, [Jennings] 1644—ab
hematuria in, [Gottlieb] 1405—ab
pneumonia simulating appendicitis in children, [White] *695
roentgen rays in, [Farani] 1998—ab
with situs inversus, [Hörnicke] 1660—ab
with unusual symptoms, [Dansey] 1003—ab
APPENDIX calculi simulating ureteral calculi, [Mark] *1689
circulatory disturbances in, [Guccione] 1305—ab
classification of positions of, [Gladstone & Wakeley] 923—ab
inflamed, pathology of, [Dudgeon & Mitchiner] 2085—ab
parasites in, [Robertson] *717
parasites in, development of oxyuris, [Wundt] 1999—ab
roentgenograms of, 1708
tooth found in, [Upton] 1570—ab
tuberculosis of, [Marcley] 1396—ab
unruptured, peritonitis with, 1632, 1883
APRAXIA and aphasia, [Bailey] 1814—ab
plantotopokinesis, [Marie & Bouttier] 665—ab
AQUEOUS HUMOR in central nervous affections, [Thiel] 343—ab
ARCH SUPPORTS, their abuse and proper indication, [Gottlieb] *295
ARGENTINA, bacteriologic institute of, 1210
ARGYLL ROBERTSON PUPILS, bilateral, cholesteatoma of third ventricle with, [Ford] *1046
ARM, pain and edema of, after effort, [Barré & Wilhelm] 1655—ab
ARMENIANS, resistance of, to arsphenamins, [Mouradian] 1736—ab
ARMY: See also under Venereal Diseases
ARMY, Citizens' Training Camps, 1277
French army health statistics during war, 315
Medical Officers' Reserve Corps, favorable response to, 44
Medical Reserve Corps, new regulations for, 53
Medical Reserve Officers, training camps for, 1208
officers, training, 983
physicians, memorial to, 1210, 1280
regular, examination for appointment in, 1454
reserve, medical section of, 1057
ARNDT-SCHULZ LAW and roentgen rays, [Frik & Krüger] 1090—ab
ARRHYTHMIA: See also Auricular Fibrillation; Ventricular Fibrillation
ARRHYTHMIA, detection of extrasystole of heart in relation to diseases of bile passages and duodenal ulcer, [Behrend] 990—C
of auricular fibrillation, [Kilgore] 1722—ab
partial disturbances of conduction, [Roth] 757—ab
quinidin for complete, [Lorenzo Gironés] 504—ab
quinidin in extrasystolic, [Musser] 820—ab
quinidin sulphate in, [Lian] 1655—ab
significance of cardiac irregularities in operability of cases of cholelithiasis, cholecystitis and duodenal ulcer, [Straus & Hamburger] *706
tension arrhythmia, [Rimbaud & others] 1153—ab
value of cardiographs in [Smith] 579—ab
ARSENIC and metabolism, [Kramář & Tomcsik] 665—ab
compounds of, cause eye lesions, [Young & Loevenhart] 1477—ab
effect of, on liver function, [MacCormac & Dodds] 500—ab
in blood after tryparsamide, [Fordyce & others] 1813—ab
in serum after medication, partition of, [Fordyce & others] 1813—ab
in spinal fluid after intravenous injection of arsphenamin, [Cornwall & Myers] 240—ab
in spinal fluid after medication, [Fordyce & others] 1813—ab
poisoning, progress of science upsets verdict of 1878, 558, 2062
the Danval affair, 2062
ARSPHENAMIN accidents, [Levy-Lenz] 931—ab, [Evrard] 1303—ab
accidents, in Morocco, [Decrop & Salle] 339—ab
and blood coagulability, [Copher] 1571—ab
arsenic content of blood after, [Fordyce & others] 1075—ab
arsenic in milk after, [Fordyce & others] 1075—ab
bilirubin determinations in blood as a measure of liver damage in treatment with, [Schamberg & Brown] *1912
cutaneous reactions after, [Klauder] *933
dermatitis, sodium thiosulphate in, [Bugg & Folkoff] 1395—ab
dermatitis, treatment of, [Miller] 60—ab, [Hoffmann & Schreus] 345—ab
estimation of sulphur in, 1903—ab
fatalities due to, 43
glucose solution for injections of, [Weitgasser] 755—ab
government inspection of, 1796
influence of, on liver functioning, [Kartamischew] 1824—ab
injuries from, [Werthern] 1741—ab
jaundice from, [Bruusgaard] 430—ab
prophylactic use of, [Rostenberg] *207
rectal administration of, [Littman & Hutton] *868, 888—E
ART and insanity, [Vinchon] 1152—ab
medical salon at Paris, 1189—ab
ARTERIES, coronary, variations in anastomosis of, and their sequence, [Oberheiman & Le-Count] *1321
carotid, compression of, [Hering] 74—ab, [Koch] 170—ab
coronary, disease of, electrocardiogram in diagnosis and prognosis of, [Oppenheimer & Rothschild] 1722—ab
coronary, suture of wound of heart ligating interventricular branch of left coronary artery and vein, [Davenport] *1840
elasticity, measuring, [Bramwell] 2086—ab
elasticity of, research on, [Tschmarke] 1657—ab
posterior inferior cerebellar, occlusion of, [Ramsbottom & Stopford] 1228—ab
pulmonary, sclerosis of, [Arrillaga] 755—ab
renal, aneurysm of, [Conroy] 241—ab
spasms, treatment of, [Meyer] 663—ab
suture of, [Avramovich] 424—ab
umbilical, closing of, [Rech] 1088—ab
vertebral, ligation of, [Izquierdo] 828—ab
ARTERIOSCLEROSIS and hyperpiesia, [Shaw] 1479—ab
and hypertension, [O'Hare & Walker] 1296—ab
blood cholesterol in, [Pribram & Klein]
diagnosis and treatment, [Douglass] 1471—ab
in thyroid deficiency, [Fishberg] *463
ARTHRITIS: See also under Hip joint
ARTHRITIS, arthropathia psoriatica, [Garrod & Evans] 823—ab
alleged rôle of lactic acid in, [Pemberton & others] 1988—ab
cervix uteri focus of infection in, [Moench] 1225—ab
deformans, [Forni] 504—ab
deformans, heart in, [Boas & Rifkin] *1596
diseases of finger joints, [Axhausen] 343—ab
focal infection, gastric ulcer and, [Nakamura] 821—ab
gonococcal, [Trigueros] 587—ab, [Borak] 1742—ab
hypertrophic, age factor in, [Willis] 1817—ab
of dental origin, [Maranón & Tapia] 342—ab

ARTHRITIS, polyarthritis after pains in teeth, [Troisier & others] 661—ab
relation of anaphylactic disturbances to, [Turnbull] *1757
seminal vesicles in, [Shea] *274
syphilitic, [Dufour & Duchon] 248—ab, [Bustos] 251—ab
syphilitic, diagnosis of, [Eisler] 1903—ab
syphilitic, tardy, [Schlesinger] 1826—ab
tuberculous, rhizomelic spondylosis from, [González Olaechea] 68—ab
with splenomegaly and leukopenia, [Felty] 747—ab
ARTHROPATHIES, neuro-arthropathies: with special reference to that form caused by peripheral nerve disease or injury, [Philips & Rosenheck] *27
ASCARIASIS of intrahepatic bile ducts, [Motta] *85
complications caused by ascarids after operations on gastro-intestinal tract, [Haim] 1903—ab
ileus from, [Lafos García] 1484—ab
intestinal obstruction caused by roundworms following santonin, [Watkins & Moss] *1442
of biliary apparatus, [Bertone] 249—ab, [Hortolomei] 424—ab
ASCARIS lumbricoides causes intestinal spasm, [Harris] 337—ab
ascaris as cause of disease, [Fanconi] 2088—ab
ASCITES, ascitic fluid, 1066
and glycosuria, [Loeper & Turpin] 2088—ab
level and quantity of, [Galli] 1483—ab
mucous, [Nelken] 1087—ab
retroperitoneal lymphocytoma causing chylous ascites and chylothorax, [Coley] *2031
ASEPSIS, aseptic departments in hospitals, [Sippel] 507—ab
disinfection of operative field, [Saikindsohn] 1157—ab
hot air in disinfection of skin, [Vogel] 506—ab
ASMOGANGLINA not accepted for N. N. R., 2068—P
ASPERMIA, azoospermia traceable to prostate, [Catzeflis] 1303—ab
ASPHYXIA pallida neonatorum, pituitary extract in, [Cormack] 1572—ab
ASSOCIATION for Development of Medical Relations Between France and Allied Countries, 223
ASTHMA and infections of accessory nasal sinuses, [Heatly & Crowe] 334—ab
and cardiac nerves, [Frey] 2093—ab
and tuberculin, [Stuhl] 345—ab
arthritis in, [Lintz] 1149—ab
botanic survey of Kansas City, Mo., and neighboring rural districts, with reference to flora responsible for, [Duke & Durham] *939
botany of southwest Texas, with reference to, [Kahn] *871
bronchomycosis associated with certain types of, [Steinfield] *83
calcium in, [Pottenger] 1143—ab
chronic malaria cause of, [Murray] 2145—ab
complicating cardiovascular disease, [Harkavy] *100
concurrent occurrence of tuberculosis and, [Ezekiel] 658—ab
electric fan in seasonal treatment of, [Kahn] 1883—C
glycerin plate for detecting nonpollen type of, [Kahn] 227—C
heredity of vegetative syndromes, [Ullmann] 1825—ab
histamin in causation of, [Ramirez & St. George] 657—ab
in children, [Beretervide & Pozzo] 1155—ab
in pharmacists, [Peshkin] *1854
nasal operations in, [Kahn] *536, [Mundt] 812—C
nonspecific protein therapy for, [Schiff] 59—ab
peptone and vaccine therapy of, [Veitch] 659—ab
sputum, [Koopman] 1488—ab
surgical treatment of, [Kümmell] 71—ab
sympathectomy in, [Glaser] 1741—ab
treatment of, [Hekman] 346—ab, [Jungmann & Brüning] 1235—ab
vaccine therapy in, [Lajoie] 1894—ab
ASTIGMATISM and heredity, [Paderstein] 70—ab
ATAVISM: See Heredity
ATAXIA, Locomotor: See Tabes Dorsalis
ATHLETICS, medical center for athletes, 987
blood pressure after ski races, [Filip] 2094—ab
heart and blood vessels of marathon runners, [Gordon & others] 1729—ab
heart in, estimation of heart function in sports, [Libensky] 2094—ab
ski injury of knee joint, [Stracker] 1659—ab
some changes in chemical constituents of blood following marathon race, with special reference to hypoglycemia, [Levine & others] *1778
ATLAS, torsion dislocation of, [Sudeck] 1087—ab
ATROPIN for diagnosis and treatment of disturbances from vascular spasm, [Abadie] 1899—ab
ATUSSIN not accepted for N. N. R., 2068—P
AUFRECHT, celebration of his 80th birthday, 1213
AURICULAR FIBRILLATION, effect on functional ability of heart, [Barringer] *516
arrhythmia of, [Kilgore] 1722—ab
digitalis in, [Jensen] 1735—ab
effect of exercise in, [Blaumgart] 1896—ab
in domestic animals, [Roos] 1896—ab
in goiter, [Baumgartner & others] 1729—ab
quinidin and digitalis in [Gordon] 1394—ab
quinidin in, [Levy] 580—ab, [Wyckoff & Ginsberg] 2081—ab
regular ventricular rhythm in, [Dock & Levine] 1991—ab
transient and recurrent, [Patterson] *453
AURICULAR FLUTTER, [Wilson] 1896—ab
AURICULARIS PHENOMENON, early signs of pulmonary tuberculosis, [Goudman-Benstz] 1406—ab
AUSCULTATION, intrathoracic, [Bondi] 1999—ab
AUSTRIA, marriages, births and deaths in, 140
appointments in Austrian universities, 1709
meeting of Austrian Antituberculosis Society, 2063
AUTOHEMOTHERAPY: See under Hemotherapy
AUTOMOBILE emblem, where shall we place our caduceus emblem? [Mendel] 648—C
Exhaust Gas: See Carbon monoxid poisoning
fatalities in death registration area in 1922, 1784—ab
fatalities in United States, 1917-1922, 24—ab
insurance for physicians, 2133
plane, medical aid in haste, [Sohn] 147—C
AUTOPSY: See Necropsies
AVIATION and anoxemia, 1694—E
aeroplane a source of disease; new epidemic danger, 902
air service ambulance, 1792
importance of sense of smell in aviators, 316
AXIS, fracture of epistropheus, [Ellermann] 1236—ab
AZOPROTEINS, anaphylaxis to, [Landsteiner] 1992—ab

B

BACILLUS: See also under names of diseases as Diphtheria; Tuberculosis, etc.
BACILLUS abortus, immunologic identity of, and Malta fever germ, [Auricchio] 663—ab
Acidophilus Therapy: See Milk, bacillus acidophilus
aertrycke, jaundice due to, [Anigstein & Milinska] 65—ab
colon, agglutination kinships, [Hamburger & Czickell] 589—ab
colon, clinical study of blood stream infection by, [Felty & Keefer] *1430
colon, "coli test" for serum protease, [Wollman & others] 1302—ab
colon, colon bacilli meningitis and pyelitis, [Sickenga & Munk] 2150—ab
colon, in urine, 1286
colon, serologic unity of, [Meyer & Löwenberg] 2092—ab
colon, treatment of infectious diseases, [Saathoff] 1659—ab
Ducrey's, isolation of Ducrey bacillus from smegma of normal men; preliminary report, [Brams] *1166
fusiformis and spirochetes cause secondary infection in tuberculosis, [Pilot & others] 333—ab
gas bacillus infection, [Hogan] 234—ab
hemophilic, study of, [Jordan & Reith] 1148—ab
histolyticus, new bacteriologic discoveries, 1518—E
lactic acid, direct treatment with, in puerperal infection, [Chirié] 1899—ab
lactic acid, fermentation by, [Lumière] 339—ab
mycoides, lysins of, [Much & Satorius] 1485—ab
Pfeiffer's, agglutinins for, in influenza and measles serum, [Sharp & Jordan] 1148—ab
proteus, agglutination of proteus X, [Sonnenschein] 852—ab
proteus, fatal infection from, [Warren & Lamb] 2083—ab
pyocyaneus, bacteriology of violescent pus, [Uyeno] 422—ab
pyocyaneus, vaccination against, [Arloing & Dufourt] 1401—ab
BACKACHE, psychoneurotic, [Courtney] 497—ab
relation of, to gynecology, [Graves] 497—ab
BACTERIA, aciduric, [Cannon] 1148—ab
acid fast, as source of vitamin B, [Damon] 1734—ab
action of serum on, [Wulff] 1828—ab
are bacteria animals or plants? 131—E
concentration of, by aluminum hydroxid, [Saelhof] 1814—ab
culture, egg albumin as medium, [Goodrich] 1285—C
BACTERIA culture, nutritive value of heated blood agar, [Soparkar] 162—ab
determining bacterial proteolysis, [Wagner & others] 498—ab
from teeth, elective localization in eye, [Haden] 417—ab
hemophilic, of normal throats, [Dible] 1734—ab
longevity of, 2070
nonsporogenous, survival of, [Puntoni] 1153—ab
solubility of, in bile, [Malone] 660—ab
thermophile, [Caillon & Catouillard] 2087—ab
transmission of allergy in bacilli, [Schnabel] 1740—ab
BACTERIOLOGY, new bacteriologic discoveries, 1518—E
teaching of, [Mackie] 581—ab
BACTERIOPHAGE (Doerr) 249—ab, [Bail & Matsumoto] 344—ab, [McKinley] 336—ab, [Phillbert] 424—ab
action of pancreatin on, [Pico] 250—ab
and trypsin, [Wollman] 926—ab
autolysis by antagonism, [Fabry & van Beneden] 926—ab
autonomy of, [d'Herelle] 826—ab
distillation of agents of, [Olsen & Yasaki] 168—ab
import of salts to, [Zdansky] 1008—ab
in dysentery feces, [Suzuki] 501—ab
influence of hydrogen ion concentration on, [da Costa Cruz] 1403—ab, 1822—ab
not a ferment, [Fiu] 74—ab
physical conditions of, [d'Herelle] 826—ab
plague bacillus bacteriophage, [Morales Villazon] 250—ab
polyvalence of, [Wolff & Janzen] 502—ab
reproduction of, [Lepper] 1081—ab
sensitization by vaccination against, [Haudurroy] 1152—ab
spontaneous appearance of lysins in cultures, [Bordet] 926—ab
therapy, [Zdansky] 2094—ab
thermoresistance of, [Doerr & Rose] 586—ab
treatment of typhoid by, [Alessandrini & Doria] 827—ab
treatment with, [McKinley] 417—ab, [Markuse] 1574—ab
BAKERIES, night work in, 1282
BALNEOLOGY, course in, 2133
BALNEOTHERAPY, effect of baths on blood concentration, [Barbour & Tolstoi] 496—ab
BANANA OIL: See Amyl Acetate
BANNING, PIERSON W., international faker, 1201—E
BANTI'S DISEASE: See Anemia, splenic
BARANY'S TESTS: See under Vestibular Apparatus
BARTHOLINITIS, gonorrheal, [Hübner] 587—ab
BASAL METABOLISM: See Metabolism, basal
BASEDOW'S DISEASE: See Goiter, exophthalmic
BATHS: See also Balneotherapy
BATHS, carbon dioxid, physiology of, [Wassermann] 2094—ab
BATTERIES, storage, lead poisoning from, 1383
"BAYER 205" kinematographic representation of a chemical synthesis, [Fourneau] 1736—ab
series of, [Fourneau & others] 1302—ab
trypanosomiasis of mice and, [Morgenroth & Freund] 665—ab
BEADS, glass, removal of, from lungs, [Aynesworth] *1414
BEANS, favorite vegetarian foods, 2052—E
BED SORES: See Decubitus
BEEF, ground, bacteriologic examination of, [Hoffstadt] 745—ab
BEES' STINGS, acute myelosis after, [Parrisius & Heimberger] 1086—ab
BEHAVIOR problems, committee to consider, 2059
BELGIUM, population of, 48
BENEDICT'S TEST: See Urine, sugar in
BENZENE poisoning, [Teleky & Weiner] 931—ab
BENZYL Benzoate: See also under Angina Pectoris, etc.
benzoate, effect of, on antibody formation, [Emge] 244—ab
BERIBERI, hoarseness in, [Fernando] 1149—ab
and rice, [McCarrison] 1300—ab, 1975—E
comparison of vitamin B deficiency with, [Ogata] 1901—ab
infant, meningeal cases of, [Suzuki & Mori] 1819—ab
metabolism in, 580—ab, 1614—E
resolution on, 557
BEVERAGES, carbonation of, not germicidal, [Donald & others] 998—ab
BILE, lyctic action of, [Joannides] 827—ab
pigment, extrahepatic formation of, [M'Nee & Prusik] 824—ab
pigments, formation of; reticula-endothelial system, [Whipple] 910—C
pigments, new test for, [Gould] 990—C
pigments, new test for, in urine, bile and blood serum, [Kapalnow] *687
production, increasing and decreasing, [Smyth & Whipple] 1892—ab
production, influence of drugs on, [Smyth & Whipple] 1892—ab

BILE, production, modification of, [Smyth & Whipple] 1891—ab
production, seat of, [Smyth & Whipple] 1891—ab
protein matter of, [Logan] 243—ab
reaction of, and gallstone formation, 1127—E
salts of, in duodenal juice of children, [Taylor and others] 575—ab
solubility of micro-organisms in, [Malone] 660—ab
BILE DUCT, common, exposure in surgery of, [Holman] *1045
common, obstruction of, by fasciola hepatica, [Maury & Pélissier] 1304—ab
hepatic, reconstruction of, [Walters] 821—ab
resorption and elimination of fat by epithelium of biliary passages, [Kusnetzowsky] 1741—ab
BILHARZIASIS: See Schistosomiasis
BILIRUBIN, in Blood: See Blood, bilirubin in
BILLS and joint liability, 416—ML
BIOCHEMISTRY at Oxford, 1453
new biochemical laboratories at Cambridge, 1876
BIOLOGY, experimental, 1453
BIRTH CONTROL and physician, [Labhardt] 827—ab
commercial exploitation of, 1209
instruction in, 1876
measure in senate, 481
sexual problems at Church Congress, 1454
study of contraception, 1056
BIRTH RATE: See also Vital Statistics
BIRTH RATE in Congo, 986
increase of male births, 1061
BIRTHMARKS: See Angioma
BISMUTH, cephalalgia from, [Bensaude & others] 661—ab
in Syphilis: See Syphilis
BLACKALL, REGINALD, martyr to roentgen rays, 1209
BLACKO KIDNEY TABLETS, 989—P
BLACKWATER FEVER, a complication of malaria, [Young] 337—ab
BLADDER calculus, blocking of lithotriptor, [Lenko] 757—ab
cancer, high frequency current and deep roentgen therapy in, [Hernández e Ibáñez] 1998—ab
cancer of, with brain metastases, [Lower & Watkins] 1474—ab
distended, gradual decompression and simultaneous lavage of, [Shaw & Young] 1732—ab
distended, imminent abortion from, [Borger] 1235—ab
disturbances of, from uterine fibromas, [Hartmann & Bonnet] 1654—ab
diverticulum of, [Simon] 70—ab, [Judd & Scholl] 657—ab
exstrophy of, new operation for, [Burns] *1587
exstrophy of, transplantation of ureters into rectum for, [Mayo & Walters] *624
exstrophy with cancer of, and absence of umbilicus, [Murphy] *784
foreign bodies in female bladder, [Lehoczky-Semmelweis] 1659—ab
foreign body, hairpin in bladder, [Barr & Allerton] 579—ab
hypertrophy of, idiopathic, [Fordyce & Capon] 1895—ab
Inflammation: See Cystitis
introduction of glass instruments into bladder condemned, [Solomon & Glasser] 1298—ab
leukoplakia in, [Li Vigni] 827—ab
necrosis and gangrene of, [Wolferth & Miller] 1474—ab
obstruction, incomplete retention of urine and sphincterectomy, [Rauch] 1235—ab
obstruction, urinary retention in boys due to, [Beer] 1145—ab
resorption from, [Lenko & Krzyzanowski] 1152—ab
rupture of, during puerperium, [Roxas & Rustia] 1227—ab
surgery, suprapubic cystotomy in kidney tuberculosis, [Rathbun] 1300—ab
transillumination of vesicovaginal septum, [Laws] *965
trigon, physiology and pharmacology of trigonum vesicae, [Young & Macht] 656—ab
varix, hematuria after roentgen and radium exposures, [Schug] 507—ab
BLIND in Iowa, [Reeder] *815
society for, 38
welfare of, 2061
BLINDNESS: See also Amblyopia
BLINDNESS, after genital hemorrhage, [Puppel] 1742—ab
from sinusitis, [Demaria] 1823—ab
National Committee for Prevention of, 43
BLISTER, infection, and refusal of lancing, 574—MI
BLOOD, action of light on, [Ramain] 163—ab
alkali reserve, [Odaira] 1158—ab
amino-acid content of, in infants, [Hoeffel & Moriarty] 575—ab
amino-acid content of, in health and disease, [Greene & others] 920—ab
BLOOD, arsenic content of, after intravenous injection of arsphenamin, [Fordyce & others] 1075—ab
as physicochemical system, [Henderson & others] 1816—ab
bilirubin determination in cholecystitis without jaundice, [Friedman & Straus] *1248
bilirubin determinations in, as a measure of liver damage in treatment with arsphenamins, [Schamberg & Brown] *1911
bilirubin in, Bergh's bilirubin reaction, [Blum] 344—ab
bilirubin in, estimation of, [Bonorino Udaondo & Carulla] 1573—ab
bilirubin in, icterus index an aid in diagnosis and prognosis, [Bernheim] *291
calcium in, and light baths, [Rothman & Callenberg] 71—ab
calcium in, and rickets, [Kneschke] 72—ab
catalase and roentgen rays, [Magat & Rother] 2150—ab
cells, conservation of, [Dold] 1741—ab
cells, effect of acids and bases on, [Bostrom] 496—ab
Cells, Red: See Erythrocytes
Cells, White: See Leukocytes
changes following therapeutic bleeding, [Grant] 336—ab
chemistry, electrolytes after food intake, [Wollheim] 1902—ab
chemistry, reciprocal relation of chlorids and glucose in blood, [Herrick] 1731—ab
chlorids, variation in, after meals, [Dodds & Smith] 661—ab
cholesterol in arteriosclerosis, [Pribram & Klein] 1903—ab
cholesterol in obliterating arteritis, [Heltz] 239—ab
cholesterol, decholesterolization, [Loeper] 662—ab
cholesterol and insulin, [Nitzescu & others] 1401—ab
chondroitin-sulphuric acid in serum, [Dresel] 505—ab
circulation, action of potassium iodid on, [Bloom] 2089—ab
circulation, discovery of, [Marraro] 251—ab
circulation, effect of temperature on, [Barcroft & Marshall] 666—ab
circulation, Kauffmann's circulation test, [Heilbronner] 1999—ab
circulation, pulmonary, described in 1553, 1199—ab
coagulability and arsphenamin, [Copher] 1571—ab
coagulation, induced secretion of antithrombin by excitation of Cyon's nerve, [de Waele & van de Velde] 1898—ab
coagulation and cholin, [Zunz & La Barre] 926—ab
coagulation and sedimentation, [Wöhlisch] 2092—ab
coagulation; calcium and thrombin, [Wöhlisch & Paschkis] 72—ab
concentration, dehydration and anhydremia, 1520—E
concentration, effect of baths on, [Barbour & Tolstoi] 496—ab
concentration, insulin hypoglycemia and anhydremia, 1269—E
Costa's reaction in, [Bagliani] 341—ab
count, modification of Bass hematocytometer for counting blood or spinal fluid, [Johns] *1045
creatin and creatinin in, [Fonteyne & Ingelbrecht] 584—ab
cultures, negative, significance of, [Straus] 1226—ab
dialysis of, in living subjects, [Ganter] 345—ab
disease, value of secretin in, [Downs & Eddy] 418—ab
diseases, acid-base balance in, [Myers & Booher] 1892—ab
dynamics of, [Jansen & others] 1825—ab
effect of addition of ether to, [Austin & Gram] 1891—ab
effect of dry and moist heat on, [Lozinsky] 496—ab
effect of mercurochrome on bacteriostatic action of, [Hill & Colston] 157—ab
effect of tissues on respiratory functions of, [Peters] 1809—ab
fat content of, in fever, 1801
fat in, effect of insulin in treatment of case of diabetic lipemia with lipemia retinalis, [Rowe] *1168
fat, micromethod for determination of, [Bing & Heckscher] 346—ab
fibrin changes in various diseases, especially in diseases of liver, [McLester & Davidson] 1809—ab
formation, derangement of hormone function, [Ehrström] 1902—ab
formation, hematopoietic effect of bone marrow and spleen, [Leake] 656—ab; 797—E
gas exchange of, and vitamin B, [Faerber & Telleria] 252—ab
gases, influence of deprival of oxygen and excess of carbon dioxid on blood and circulation, [Popescu-Inotesti & Gabriel] 1488—ab
group specific antibodies, [Schiff] 1826—ab
grouping tests before skin grafts, [Kubányi] 2090—ab
BLOOD, groups, agglutinin differentiates 2 types of group II erythrocytes, [Huck & Guthrie] 747—ab
groups, artificial changes in, [Esposito] 1006—ab
groups, classifications of human agglutinating serums, 991
groups, influence of temperature on isohemagglutination, [Guthrie & Pessel] 1147—ab
groups, iso-agglutinins D and Q in human blood, [Guthrie & Pessel] 1730—ab
groups, iso-agglutinins in blood of new-born, [Happ & Zeiller] 227—C
groups, isohemagglutination, [Kirihara] 1487—ab
groups, isolysin groups, [Mino] 1006—ab
groups, matching of bloods, [Levine & Mabee] 243—ab
groups, racial, [Manulla & Popoviciu] 1402—ab
groups, types of group IV blood, [Guthrie & Pessel] 1395—ab
inorganic salts in, in pregnancy, [Underhill & Dimick] 243—ab
insulin in, 1732—E
iron in, of new-born, [Gallo] 2089—ab
lipase in pulmonary tuberculosis, [Wooley] 1392—ab
lipoid content of, from umbilical cord and from mother, [György] 1575—ab
lipolytic ferments in, [Vanýsek & Felklová] 831—ab
microscopy of, in surgery, [Stahl] 1404—ab
nitrogen, nonprotein, 1519—E
nitrogen, nonprotein, in eclampsia and allied conditions, [Plass] *266
nitrogen, nonprotein, and heart and kidney changes, [Floyd] 1476—ab
normal, nucleotide in, [Jackson] 1891—ab
oxygen, aviation and anoxemia, 1694—E
phosphate after insulin convulsions, [Winter & Smith] 1391—ab
phosphorus, determination of, [Smith & Brown] 336—ab
phosphorus in cancer, [Zerner] 1309—ab
picture, diagnostic value of, [Cruickshank] 1082—ab
picture in young children, [Frankenstein & Stecher] 1008—ab
pigment, objective determination of, [Wolvius] 668—ab
platelet variation in "colds," [Bannerman] 1081—ab
platelets, 731
platelets and light, 212—E
platelets and malignant tumors, [Rosenbaum] 1309—ab
platelets, bone marrow in thrombopenia, [Jedlicka] 253—ab
platelets in hemophilia, [Feissly & Fried] 2092—ab
platelets, splenectomy for essential thrombocytopenia, [Brill & Rosenthal] 417—ab, [Engel] 2090—ab
platelets, splenectomy in treatment of hemorrhagic conditions, [Wild] 1741—ab, (Correction) 2000—ab
platelets, thrombopenia and aleukia, [Seeliger] 1902—ab
preserving, for chemical analysis, [Sander] 243—ab
preserving, with liquor formaldehydi, [Bock] 1225—ab
protease, "coli test" for, [Wollman & others] 1302—ab
sodium and potassium content of, in disease, [McVicar & Ross] 158—ab
streptococci in, [Freund & Berger] 2091—ab
sugar and diabetes, [Pal] 1743—ab
sugar and suprarenals, [Griffith] 155—ab
sugar and thyroid and suprarenals, [Riddle & others] 997—ab
sugar, aseptic glycolysis, [Bierry & others] 1303—ab
sugar, changes in, [Rotky] 1999—ab
sugar, combined, [Condorelli] 1305—ab
sugar, effect of alcohol on, [Blatherwick & others] 496—ab
sugar, effect of cold weather on, [Riddle & Honeywell] 496—ab
sugar, Epstein method for, 991, 1802
sugar, estimation of, by Folin-Wu method using 0.1 C.C. of blood, [Randles & Grigg] *684
sugar, glycemia curve and hypothalamus, [Vanýsek] 2094—ab
sugar, glycemic reaction to small doses of sugar in infants and young children, [Rumpf] 1404—ab
sugar, hyperglycemia and oxygen inhalation, [Pinali] 425—ab
sugar, hypoglycemia after insulin, [Sevringhaus & others] 58—ab
sugar, hypoglycemic reaction, [Lax & Petényi] 1826—ab
sugar in infants, [Muggia] 828—ab
sugar of Filipinos, [Concepcion] 580—ab
sugar, picrotoxin hyperglycemia and insulin, [Kogan] 2091—ab
sugar reaction, [Niemeyer] 757—ab
sugar, reflex hyperglycemia, [Griffith] 155—ab
sugar, relations between glycemia, blood pressure and kidney function, [Alello] 1305—ab

BLOOD, sugar, some changes in chemical constituents of blood following marathon race, with special reference to development of hypoglycemia, [Levine & others] *1778
tests, biologic oneness of mother and child, [Mayer] 344—ab
tests, erroneous interpretation of, by employee, 1387—ML
thermodynamic relations of oxygen and base combining properties of, [Stadie & Martin] 1988—ab
transfusion, [Dick] 2084—ab
transfusion, anaphylaxis in, [Böttner] 2091—ab
transfusion and reinfusion, [Zimmermann] 70—ab
transfusion, cardiovascular reactions to hemorrhage and, 1866—E
transfusion, citrated; experimental study of toxicity of sodium citrate in exsanguinated dogs, [Joannides & Cameron] *1187
transfusion, effect of gum solution and transfusion on brain, [Crile & others] 1225—ab
transfusion, immunotransfusion, [Colebrook & Storer] 422—ab
transfusion, intraperitoneal blood infusion, [Opitz] 1902—ab
transfusion, intraperitoneal, in infants, [Ruh & McClelland] 244—ab
transfusion, intravenous own blood transfusion, [Roseno] 1235—ab
transfusion made safer, [Fisk] 568—C
transfusion, measles transmitted by, [Baugness] 1223—ab, 1448—E, [Harrell] 1812—ab
transfusion, pure versus citrated blood, [Pauchet] 1230—ab
transfusion, results of, with citrated blood, [Lewisohn] 1815—ab
transfusion, shadows of erythrocytes after, [Van der Hoff] 1736—ab
urea nitrogen, determination of, [Karr] 1226—ab
uric acid in, increase of uric acid in blood during prolonged starvation, [Lennox] *602
venous, composition of, [Schwensen] 1236—ab
vessels and digitalis group, [Ganter] 1903—ab
vessels, function of surviving vessels, [Krawkow] 1233—ab
vessels, large abdominal, ligation of, [Offergeld] 1085—ab
vessels, surgery of, [Prat] 1900—ab
viscosity, hydration of serum proteins, [Spiro] 71—ab
viscosity, measurement of, [Soler & Tedeschi] 753—ab
volume of, at high altitudes, [Laquer] 588—ab
BLOOD PRESSURE and glycemia and kidney function, [Aiello] 1305—ab
after ski races, [Filip] 2094—ab
capillary, in arterial hypertension, [Boas & Mufson] 335—ab
diastolic, [Engelen] 1738—ab
diastolic, measurement of diastolic pressure, [Sahli] 170—ab
diastolic paradox, [Miller] *1511
effect of methyl guanidin on, [Major & Stephenson] 2082—ab
effect of sodium nitrate on blood pressure; urinary response, [Mason] 2083—ab
high, and arteriosclerosis, [O'Hare & Walker] 1296—ab
high, association of, with suprarenal tumors, [Oppenheimer & Fishberg] 2077—ab
high, cardiac hypertrophy and nephritis, [White] 497—ab
high, and dyspnea, [Cobet] 664—ab
high, and increased metabolism, [Mannaberg] 756—ab
high, buttermilk as a food, 1565
high, causes of permanently high blood pressure, [Faber] 1158—ab
high, cerebral disturbances in, [Donzelot] 1737—ab
high, constitution and, [Schmidt] 252—ab
high, epinephrin sensitivity in, [Hetényi & Sümegi] 836—ab
high, essential, [Kykin] 168—ab
high, food restriction lowers blood pressure, [Selman] 159—ab
high, heart in, [O'Hare & Walker] 1815—ab
high, heredity in, [O'Hare] 1888—ab
high, study of cases with marked hypertension, adequate renal function and neuroretinitis, [Keith & Wagener] 1808—ab
high, tinnitus aurium with, [Wharry] 1897—ab
high, treatment of, [Weiler] 929—ab, [Grober] 1089—ab
high, vascular hypertension increases intraocular pressure, [Adler & others] 1890—ab
in anesthesia, [Long] 1217—C
in different areas, [Fischer] 1902—ab
in early life, 2122—E
in new-born, [Rucker & Connell] 575—ab
in normal subjects, [Faber & Mackeprang] 1904—ab
in operative surgery and general anesthesia, [Coburn] *1748
in prognosis and treatment, [Fahrenkamp] 1007—ab
low, causes vertigo, [Lake] 1400—ab
of normal Chinese, [Cadbury] 64—ab
BLOOD PRESSURE, relation of, to amount of renal tissue, [Anderson] 1992—ab; 2123—E
relation of, to heart and kidney changes, [Floyd] 1476—ab
systolic, variations in, 1287
systolic blood pressure deception test, 1987—MI
BLOODLETTING, local, in acute inflammatory processes, [van Balen] 758—ab
BOARD OF EDUCATION versus Board of Health as to requiring vaccination, 1069—MI
BOAS' TENDER POINTS, [Szemző] 1307—ab
BONE disease, sympathetic, [Martin] 1657—ab
disorders of, induced by war-time dietary conditions, 1447—E
formation, ossification in round ligament, [Calzavara] 1310—ab
fragility, osteoporosis relieved by sympathectomy; report of case, [Heyman] *1333
grafts, [Imbert] 163—ab
grafts, growing power of transplanted periosteal callus, [Klinkerfuss] 2146—ab
growth of, in bladder incision wound, [Boss] 1405—ab
growth of, relation of diet to, [Bethke & others] 243—ab, [Toverud] 578—ab
marrow and spleen, hematopoietic effects of, 797—E
marrow, effect of irradiation on, [Falconer & others] 1813—ab
marrow of calf, soup from, [Wiltschke] 342—ab
marrow, function of, [Habetin] 589—ab
marrow in thrombopenia, [Jedlicka] 253—ab
marrow, red, hematopoietic effect of, [Leake] 636—ab
repair, function of periosteum in, 1694—E
repair, importance of endosteum and periosteum in, [Haas] 1223—ab
sarcoma, giant cell, prognosis in, [Coley] 1392—ab, 1645—ab
sarcoma, giant cell, with metastasis, [Turner & Waugh] 576—ab
sarcoma of forearm, [Di Bernardo] 1900—ab
sarcoma, primary, [Gobbi] 1482—ab
sarcoma, registry of, [Codman] 1882—C
Tuberculosis: See also Tuberculosis, surgical
tuberculosis, local treatment of, [Pattison] 584—ab
tuberculosis, roentgen-ray in, [Petersen & Heilmann] 2140—ab
tumors, blood changes in metastasis of, [Piney] 2085—ab
tumors, diagnosis of, [Hilzrot] 1642—ab
war osteopathies, [Loll] 253—ab
BONUS BILL discriminates against public health officers, 1454, 1559
method of computing bonus, 1874
BOOK, expert need not get book nor point out passage, 996—MI
BOOK OF JOSEPH, selections from "Book of Joseph, which is a collection of all therapeutics," [Lichtwardt] *652
BOTTLE-HOLDER, bedside, [Angle] *628
BOTULISM, clostridium, culture of, [Bachmann] 1078—ab
pathologic physiology of, [Edmunds & Kelper] 1809—ab
toxin, absorbed from wounds, 1613—E
toxin, acidification of, 1364—E
toxin, action delays action of, [Bronfenbrenner & Weiss] 1647—ab
toxin, effect of glucose on production of, [Dozier & others] 498—ab
BOWEL: See Intestines
BOXING, death from cardiac inhibition during, 1622
fatalities during, [Munck] 254—ab
traumatic lesions from, [Braine & Ravina] 184—ab
BRACE, simple and invisible drop-foot brace, [Galland] *30
BRADYCARDIA, mechanism of, [Hermans & Ladon] 1898—ab
BRAIN: See also Cerebellum; Cranium
BRAIN abscess, [Bagley] 657—ab
abscess, mortality of, [Sharpe] 922—ab
abscess, streptothrix found in, [Steele] 2083—ab
abscess, subcortical, drainage of, [Coleman] 234—ab
brain of a prodigy, 1797
cancer, metastasis from bladder, [Lower & Watkins] 1474—ab
cells have specific inhibitory function, [Hunt] 1475—ab
changes in, during starvation, [Hassin] 1815—ab
creatinin formation in, [Hammett] 1816—ab
hemorrhage, intracranial birth hemorrhages, 395—E, [Sharpe & Maclaire] 1001—ab
hemorrhage, puzzling cases, [Wortman & Goudriaan] 1744—ab
hernia, congenital cerebral hernia, [Lampert & Russia] 1001—ab
injections of alcohol into animal brain cortex, [Koljubakin & Uroda] 1487—ab
lesions, eyelid reflex with, [Grueter] 169—ab
lesions, residual encephalopathies in children, [Dámaso Rodrigo] 1483—ab
localization of cortex function by associative motor reflexes, [Bechterew] 662—ab
BRAIN of prehistoric child, size and shape of, [Anthony] 163—ab
perception of right and left sides, [Elze] 1826—ab
pneumoventricle of, following skull fracture, [Teachenor] 241—ab
Pressure in: See Intracranial Pressure
puncture, decompressive trephining and puncture of ventricle, [Barré & Morin] 164—ab
puncture, suboccipital, [Wartenberg] 2149—ab
roentgenography, [Adson & others] 1000—ab
roentgenography in infants, [Mader] 168—ab, [Knoepfelmacher] 1404—ab
surgery, repair of dural and brain defects by free fat and fascial transplants, [Halstead & Caylor] *1337
surgery, sheet mica in, [Kane] 1714—C
tumors, [Bickel & Frommel] 425—ab, 1084—ab
tumors, cerebellopontile, [Mertens] 1574—ab
tumors, cranial vascularity and intracranial disease, [Elsberg & Schwartz] 1297—ab
tumors, malignant spheno-occipital chordoma, [Burrow & Stewart] 582—ab
tumors of right temporal lobe, [Castex & Camauer] 929—ab
tumors, saline solution in cases of, [Cohen] 1300—ab
tumors, suprasellar, cerebellar symptoms produced by, [Bailey] 918—ab
tumors, surgical treatment of cystic glioma in brain, [Martin] 67—ab
tumors of third ventricle, [Jumentié & Chaussebianche] 1304—ab
BREAD, [Neumann] 71—ab
brown bread vs. white, 1797
BREAST anomalies, 4 generations of polymastia, [Klinkerfuss] *1247
cancer, [Küttner] 1574—ab, [Short] 1994—ab
cancer, bilateral, following prolonged irritation, [McGraw & Schrankel] *2028
cancer, combined roentgenologic and surgical treatment of, 731, [Pfahler] 1398—ab
cancer, diagnosis of, [Battle] 583—ab
cancer, inoperable, roentgen-ray treatment of, [Beck] 1657—ab
cancer, irradiation and surgery for, [Kelly & Fricke] 1300—ab
cancer in men, [Bussa Lay] 827—ab
cancer, multiple skeletal metastases from, [Thompson & Keiller] 1300—ab
cancer, postoperative irradiation, [Wassink & van Raamsdonk] 831—ab
cancer, postoperative, prophylactic irradiation of, [Lehmann] 1309—ab
cancer, preoperative and postoperation radiation in, [Sistrunk] 1398—ab
cancer, preoperative radiotherapy of, [Bowling] 1226—ab
cancer, structural alteration in, [Hanrahan] 1147—ab
cancer, surgical problems in, [Pruitt] 1812—ab
cystic disease of, [Jensen] 346—ab
exaggerated gynecomazia, [Gibson] 422—ab
gumma of, [Adair] 821—ab
hemorrhage, apoplexy of breast, [Cutler] *1763
hypertrophy; mazoplasia, [Cheatle] 1819—ab
Inflammation: See Mastitis
tuberculosis of, [Raw] 1818—ab
tumors of, [Watters] 1077—ab
tumors of, benign, [Bloodgood] 1145—ab
BREATHING: See Respiration
BRITISH MEDICAL ASSOCIATION, action of physician against, 1277
establishes prize for general practice, 2060
membership of, 2131
BROMID eruption due to bromo-seltzer, [Waugh] *1584
sodium bromid poisoning, endemic, [Gralka] 1088—ab
BROMO-SELTZER, bromid eruption due to, [Waugh] *1584
BRONCHIECTASIS, diagnosis of, [Sergent & Cottenot] 826—ab
dry hemoptysic type of, [Bezançon & others] 826—ab
graded extrapleural thoracoplasty for, [Hedblom] 823—ab
surgical treatment of, [Archibald] 1394—ab
BRONCHITIS, chronic, climatotherapy of, [Graves] 337—ab
chronic fibrinous, as symptom of mediastinal compression, [Mulligan & Spencer] *791
chronic, vaccine therapy of, [Symes] 337—ab
pathogenesis of infections; bronchitis, [Oliver] 1995—ab
treatment of, [Mahlo] 428—ab
BRONCHOMONIASIS, [Pijper] 501—ab
BRONCHOMYCOSIS associated with certain types of bronchial asthma, [Steinfeld] *83
BRONCHOPHONY, Hungarian phthisiology, [Kuthy] 928—ab
BRONCHOSCOPY in therapy of suppurative diseases of lungs, [Moore] *1036
in treatment of lung abscess and bronchiectasis, [McCrae & Funk] 1809—ab
BRONCHUS, closure of large bronchi, [Bettmann] 823—ab
BRUCK'S SYPHILIS REACTION in 12,000 tests, [Becker] 1575—ab
BRUSSELS Medical Convention, 1877
BULKLEY, L. DUNCAN, and "cancer," [Hulet] 1285—C, [Whitehouse & McWilliams] 1630—C

BUREAU OF REGISTRATION, for positions in fundamental sciences, [Edmunds] 1065—C
BURNS, extensive, method for applying paraffin to, [van Wagenen] 990—C
chlorinated lime treatment of, [Tomb] 1895—ab
death from, [Brancati] 2089—ab
sodium bicarbonate locally for, [Jones & Keegan] 657—ab
superficial, toxemia of, 37—E, [Gallie] 324—C
BURSITIS, syphilitic; (luetic bursopathy of Verneuil), [Lane] ✱852
BUSINESS, mental sufficiency for transaction of,—definitions, 1466—MI
BUTESIN PICRATE, 876
BUTTERMILK as a food, 1565
BUTYN not satisfactory anesthetic, [Thomson] 1002—ab

BOOK NOTICES

Abdominal Diseases, Acute, Diagnosis and Treatment of, 1986
Abt, I. A., Pediatrics, 1885
Adams, J. E., Diagnosis and Treatment of Acute Abdominal Diseases, 1986
Adolescent Interests, 1636
Aikens, C. A., Studies in Ethics for Nurses, 572
Alcohol and Prohibition in Their Relation to Civilization and Art of Living, 570
Alcoholic Fermentation, 1141
Alexander, F. M., Constructive Conscious Control of the Individual, 817
Alibert, J. L., Médecin de l'Hôpital Saint-Louis, 493
Allen's Commercial Organic Analysis, 816
Anesthesia, Conduction and Infiltration Anesthesia, 650
Anesthesia, Local, 817
Axhausen, G., Die Chirurgie des Anfängers, 817
Bacon, C. S., Obstetrical Nursing, 1885
Bacteriology, Bergey's Manual of, 153
Bacteriology, Fighting Foes Too Small to See, 1464
Bacteriology, Principles of, 651
Bailliart, P., La Circulation Rétinienne, 1463
Bandaging, 1292
Bárány, R., Die Radikaloperation des Ohres ohne Gehörgangsplastik bei chronischer Mittelohreiterung, 817
Barker, L. F., Blood Pressure, Cause, Effect and Remedy, 2142
Barnes, F. M., Jr., An Introduction to the Study of Mental Disorders, 1069
Bendix, B., Lehrbuch der Kinderheilkunde für Aerzte und Studierende, 914
Bérard, L., Le Cancer Thyroïdien, 1804
Bergey, D. H., Bergey's Manual of Determinative Bacteriology, 153
Bessemans, A., L'Encéphalite Léthargique; ses Particularités en Belgique, 1069
Bickham, W. S., Operative Surgery, 1635
Biology, Physical Basis of Life, 572
Biology, theoretische Biologie vom Standpunkt der Irreversibilität des Elementaren Lebensvorganges, 914
Biometry, Introduction to Medical Biometry and Statistics, 232
Blood Chemistry, 571
Blood grouping, l'Individualità del Sangue nella Biologia, nella Clinica e nella Medicina Legale, 329
Blood Platelets, l'Hématoblaste Troisième Élément du Sang, 329
Blood Pressure, Cause, Effect and Remedy, 2142
Boas, I., Habitual Constipation, 233
Botany, Pharmaceutical, 233
Botany, The Pharmacists' Botany, 1385
Bowman Lecture, 1923, 1884
Brand, A. T., Clinical Memoranda for General Practitioners, 1292
Braun, H., Local Anesthesia, 817
Brodler, L., J.-L. Alibert, Médecin de l'Hôpital Saint-Louis, 493
Broncho-Pneumonie du Nourrisson, 1885
Brophy, T. W., Cleft Lip and Palate, 914
Bruck, C., Handbuch der Serodiagnose der Syphilis, 1804
Burrage, W. L., History of Massachusetts Medical Society, 571
Cabot, R. C., Physical Diagnosis, 1068
Cammidge, P. J., Insulin Treatment of Diabetes, 1384
Cancer, Les Cancers, 1804
Cancer, L'État Actuel du Problème du Cancer, 1804
Carreras, F., Protecció a la dona Grávida, 571
Carter, W. E., Management of the Sick Infant, 1463
Chalier, A., Cancer du Rectum, 1636
Chemistry, Allen's Commercial Organic Analysis, 816
Chemistry, Fundamentals of Organic and Biologic Chemistry, 1221
Chiene, G. L., Handbook of Surgery, 914
Child Welfare, Problems of, 2075
Clark, W. M., Determination of Hydrogen Ions. An Elementary Treatise on the Hydrogen Electrode, Indicator and Supplementary Methods, 995
Cleft Lip and Palate, 914
Cole, N. B., Blood Pressure, Cause, Effect and Remedy, 2142
Collins, E. T., Arboreal Life and the Evolution of the Human Eye, 1068
Colloids, Théorie Colloïdale de la Biologie and de la Pathologie, 153
Colonic Therapy in the Treatment of Disease, 1068
Constipation, Habitual, 233
Council on Pharmacy and Chemistry of the American Medical Association, Investigations of the Therapeutic Research Committee of, 1986
Crampton, C. W., Physical Exercise for Daily Use, 1566
Curie, M., Pierre Curie, 415
Curie, Pierre, 415
Cystoscopy; Endoscopie Opératoire des Voies Urinaires, 2076
Dalrymple, W. H., Livestock Sanitation, 1717
Davenport, F. I., Adolescent Interests, 1636
Davis, L. E., Neurologic Diagnosis, 1291
Deaver, J. B., Excursions into Surgical Subjects, 328
DeLee, J. B., Obstetrics for Nurses, 2141
Delinquency, An Experimental Study of Psychopathic Delinquent Women, 1384
Demelin, L. A., Manuel de l'Accoucheur, 742
Dentistry, Radiodontia (Dental Radiography and Diagnosis), 1385
Diabetes, Primer for Diabetic Patients, 572
Diabetes, Verordnungsbuch und diätetischer Leitfaden für Zuckerkranke, 572
Diabetes Mellitus, Insulin Treatment of, 1384
Diabetes Mellitus, Treatment of, 652
Diabetic Metabolism with High and Low Diets, 913
Diagnosis, Clinical, by Laboratory Methods, 493
Diagnosis, Clinical Laboratory Diagnosis, 1069
Diagnosis, Physical, 1068
Dickson, F. D., Exercise for Health and Correction, 153
Diet, Teeth, and Health, 1463
Dietetics for Nurses, 2142
Dietetics, New, 329
Digestive Disturbances in Infants and Children Roentgenologically Considered, 232
Disease in Captive Wild Mammals and Birds, 1717
Diveley, R. L., Exercise for Health and Correction, 153
Duroux, E., Les Cancers, 1804
Ehrenberg, R., Theoretische Biologie vom Standpunkt der Irreversibilität des Elementaren Lebensvorganges, 914
Eisenberg, A. A., Principles of Bacteriology, 651
Elektrotherapie, 571
Elliott, M. B., Beginning Again at Ararat, 1636
Killthorpe, D., Primer for Diabetic Patients, 572
Embryology, Vertebrate, 1292
Encéphalite Léthargique; ses Particularités en Belgique, 1069
Endocrine Diseases Including Their Diagnosis and Treatment, 55
Endocrines, die Krankheiten der Endokrinen Drüsen, 652
Endocrines, les Sécrétions Internes, 652
Entomology, Medical and Veterinary, 1464
Eugenics, a Bibliography of, 1292
Eugenics; Marriage and Syphilis, 571
Exercise for Health and Correction, 153
Exercise, Physical Exercise for Daily Use, 1566
Falk, I. S., Principles of Vital Statistics, 235
Falta, W., Endocrine Diseases Including Their Diagnosis and Treatment, 55
Ferguson, J. H., A Combined Text-Book of Obstetrics and Gynaecology, 1220
Fiessinger, N., Les Ferments des Leucocytes en Physiologie, Pathologie et Thérapeutique générales, 1804
First Aid for Merchant Seamen, 1384
Foley, M. J., Primer for Diabetic Patients, 572
Forsdike, S., Effects of Radium upon Living Tissues, 1385
Fowler, J. K., Problems in Tuberculosis, 2074
Fox, H., Disease in Captive Wild Mammals and Birds, 1717
Franz, S. I., Nervous and Mental Re-Education, 1220
Freyre, J. D., Glosario de Semiologia, 1986
Friedenwald, J., Dietetics for Nurses, 2142
Gallbladder, Chirurgie des Voies Biliaires, 232
Gastro-Intestinal Tract; Appareil digestif, 1718
Gastro-Intestinal Tract, Lehrbuch der Magen- und Darmkrankheiten, 743
Genito-Urinary Diseases and Syphilis, 1464
Goodnow, M., Outlines of Nursing History, 572
Gräff, S., Die Lungenphthise, 492
Graves, W. P., Gynecology, 493
Gray, A. A., Atlas of Otology, 1221
Gray, H. F., Elements of Public Health Administration, 415
Griffith, J. P. C., The Care of the Baby, 1464
Growth, Chemical Basis of Growth and Senescence, 651
Gruenberg, B. C., Parents and Sex Education, 1385
Guy, J., Pulmonary Tuberculosis, 995
Gymnastics, Corrective, Manual of, 492
Gynecology, 493
Gynecology, die Röntgenstrahlenbehandlung in der Gynäkologie, 328
Gynecology and Obstetrics, Combined Text-Book of, 1220
Hanns, A., Les Sécrétions Internes, 652
Harden, A., Alcoholic Fermentation, 1141
Hart, R. W., Manual on Ship Sanitation and First Aid for Merchant Seamen, 1384
Hartmann, H., Chirurgie des Voies Biliaries, 232
Hayem, G., L'Hématoblaste Troisième Élément du Sang, 329
Hayhurst, E. R., Industrial Health, 1463
Hearing, 2142
Heart Disease, Modern Methods in Diagnosis and Treatment of, 1291
Heart Records, Their Interpretation and Preparation, 651
Heatherley, F., Modern Methods in Diagnosis and Treatment of Heart Disease, 1291
Hegner, R. W., Human Protozoology, 1718
Hellpach, W., Die geopsyschischen Erscheinungen, Wetter und Klima, Boden und Landschaft in ihrem Einfluss auf das Seelenleben, 1566
Hendry, J., A Combined Text-Book of Obstetrics and Gynecology, 1220
Heredity, Einführung in die Allgemeine und Spezielle Vererbungspathologie des Menschen, 570
Herms, W. B., Medical and Veterinary Entomology, 1464
Hernia, 1141
Hernia and Its Radical Cure, 2075
Herrick, C. J., An Introduction to Neurology, 1717
Herrman, G. R., Methods in Medicine 1986
Hill, T. C., Manual of Proctology, 650
Histology, Manual of, 415
Hoffman, M. E., A Manual of Nursing Procedures, 1637
Holmes, S. J., A Bibliography of Eugenics, 1292
Hospital Corps Handbook, United States Navy, 1923, 1637
Hospitals, Architectural Designs for Small Hospital, 743
Hoxie, G. H., Medicine for Nurses and Other Public Health Workers, 1464
Hutchinson, J., Hernia and Its Radical Cure, 2075
Hutton, I. E., Hygiene of Marriage, 153
Huzella, T., Krieg und Frieden im Lichte der Medizin, 650
Hydrogen Ions, Determination of, 995
Hygiene, Woman's Physical Freedom, 1292
Income Tax, Federal Income Taxes; Principles and Practice, 571
Industrial Health, 1463
Infants; Care of the Baby, 1464
Inhalationstherapie, Technik, 415
Insurance, Social, Protecció a la dona Grávida, 571
Intestines, Toxaemia of Acute Intestinal Obstruction or Vomiting as a Pathological Force, 743
Isaac, S., Verordnungsbuch und diätetischer Leitfaden für Zuckerkranke, 572
Jaches, L., Clinical Roentgenology of Diseases of the Chest, 914
Jakob, A., Die Extrapyramidalen Erkrankungen, 1884
Jennings, H. L., A Manual of Nursing Procedures, 1637
Jones, E. K., Hospital Library, 1292
Jonnesco, T., Le Sympathique Cervicothoracique, 816
Joslin, E. P., Diabetic Metabolism with High and Low Diets, 913
Joslin, E. P., Treatment of Diabetes Mellitus, 652
Jullien, W., Inégalité Pupillaire et Tuberculose Pulmonaire, 55
Katsainos, G. M., Marriage and Syphilis, 571
Keith, J. L., Clinical Memoranda for General Practitioners, 1292
Kellogg, J. H., New Dietetics, 329
Kerley, C. G., Digestive Disturbances in Infants and Children Roentgenologically Considered, 232
Kerr, J. M. M., A Combined Text-Book of Obstetrics and Gynaecology, 1220
Knowles, F. C., Diseases of Skin, 743
Kober, G. M., Industrial Health, 1463
Kowarschik, J., Elektrotherapie, 571
Krause, P., Handbuch der Röntgentherapie, 2142
Küpferle, L., Die Lungenphthise, 492
Lagrange, H., La tuberculose du Tractus Uvéal, Infection et Superinfection, 1385
Lathrop, E. C., Allen's Commercial Organic Analysis, 816
Lattes, L., L'Individualità del Sangue nella Biologia, nella Clinica e nella Medicina Legale, 329
Leprosy, Neurological Aspect of, 1292
Leukocytes, les Ferments des Leucocytes en Physiologie, Pathologie et Thérapeutique Générales, 1804
LeWald, L. T., Digestive Disturbances in Infants and Children Roentgenologically Considered, 232
Library, the Hospital Library, 1292
Lillie, R. S., Protoplasmic Action and Nervous Action, 1291
Lippitt, L. C., Manual of Corrective Gymnastics, 492
Liver, Enfermedades del Hígado y del Pancreas, 1804
Livestock Sanitation, 1717
Lockhart-Mummery, P., Diseases of Rectum and Colon, 54

BOOK NOTICES—Continued

Loewenstein, E., Handbuch der gesamten Tuberkulose-Therapie, 1384
Lucas, W. P., Children's Diseases for Nurses, 1885
Luckett, G. S., Elements of Public Health Administration, 415
Lumière, A., Théorie Colloïdale de la Biologie and de la Pathologie, 153
McCrae, A., Procedures in Nursing, 572
MacCurdy, J. T., Problems in Dynamic Psychology, 54
MacDonald, Y. M., Mental Hygiene and the Public Health Nurse, 1637
McEwen, R. S., Vertebrate Embryology, 1292
McFarland, J., Fighting Foes Too Small to See, 1464
McFarland, J., Surgical Pathology, 2075
MacPherson, W. G., History of Great War Based on Official Documents; Medical Services on Western Front and During the Operations in France and Belgium in 1914 and 1915, 571
Mangold, G. B., Problems of Child Welfare, 2075
Marie, W., Lexikon der gesamten Therapie des praktischen Arztes, 415
Martin, H. D., Study of Workmen's Compensation, Insurance Laws and Service, Monopoly or Competition, 1921
Martius, H., Die Röntgenstrahlenbehandlung in der Gynäkologie, 328
Massachusetts Medical Society, History of, 571
Medicine, Clinical Memoranda for General Practitioners, 1292
Medicine, Diagnostische und Therapeutische Irrtümer und deren Verhütung, 1292
Medicine, Irrtümer der Allgemeinen Diagnostik und Therapie sowie deren Verhütung, 1463
Medicine, Krieg und Frieden im Lichte der Medizin, 650
Medicine, Manual of Practice of, 232
Medicine, Methods in, 1986
Melrowsky, E., Die Syphilis, 1804
Mendel, L. B., Nutrition: The Chemistry of Life, 1464
Mental Disease, Nervous and Mental Re-Education, 1226
Mental Disorders, Introduction to the Study of, 1069
Mental Hygiene and the Public Health Nurse, 1637
Meyer, J., La Broncho-pneumonie du Nourrisson, 1885
Military Medicine, History of Great War Based on Official Documents; Medical Services on Western Front, and During the Operations in France and Belgium in 1914 and 1915, 571
Mitchell, C. A., Allen's Commercial Organic Analysis, 816
Mönckeberg, J. G., Ribberts Lehrbuch der Allgemeinen Pathologie und der Pathologischen Anatomie, 153
Mondor, H., Cancer du Rectum, 1636
Monrad-Krohn, G. H., The Neurological Aspect of Leprosy ("Spedalskhed"), 1292
Moodie, R. L., Paleopathology, 742
Moore, H., Public Health in the United States, 152
Morris, R. S., Clinical Laboratory Diagnosis, 1069
Morton, H. H., Genito-Urinary Diseases and Syphilis, 1464
Mosher, C. D., Woman's Physical Freedom, 1292
Mottram, V. H., Manual of Histology, 415
Muszkat, A., Technik der Inhalationstherapie, 415
Near East Relief; Beginning Again at Ararat, 1636
Near East Relief, Medical Work of, 1566
Nelis, C., L'encéphalite léthargique; ses Particularitiés en Belgique, 1069
Nervous System, Introduction to the Histology and Histopathology of, 816
Nervous System, le Sympathique Cervico-Thoracique, 816
Neumann, W., Die Klinik der beginnenden Tuberkulose Erwachsener, 1291
Neurology, An Introduction to, 1717
Neurology, Neurologic Diagnosis, 1291
Neuropathology, die Extrapyramidalen Erkrankungen, 1884
Nevin, M., Conduction and Infiltration Anesthesia, 650
Newsholme, A., The Elements of Vital Statistics in Their Bearing on Social and Public Health Problems, 1803
Noguchi, H., Laboratory Diagnosis of Syphilis, 493
von Noorden, C., Verordnungsbuch und diätetischer Leitfaden für Zuckerkranke, 572
Nose, Intranasal Surgery, 1636
Nouveau traité de médecine, Fascicule XIII, Appareil Digestif, 1718
Nurses, Children's Diseases for, 1885
Nurses, Medicine for Nurses and Other Public Health Workers, 1464
Nurses, Obstetrics for, 2141
Nurses, Studies in Ethics for, 572
Nursing, Handbook for Mental Nurses, 1141
Nursing, History, Outlines of, 572
Nursing, Obstetrical, 1885
Nursing Procedures, A Manual of, 1637
Nursing, Procedures in Nursing, 572
Nutrition: The Chemistry of Life, 1464
Obstetrics and Gynaecology, Combined Text-Book of, 1220
Obstetrics for Nurses, 2141
Obstetrics, Manuel de l'Accoucheur, 742
Obstetrics, Physiologie Obstétricale, Normal et Pathologique, 651
Ogden, R. M., Hearing, 2142
Old Age; Geriatrics, 1717
Ophthalmic Year Book, Volume XIX, 817
Ophthalmology, Arboreal Life and the Evolution of the Human Eye, 1068
Oral Hygiene, 1464
Orthopaedic Surgery, Selected Essays on, 2074
Orthopedic Surgery, Surgery of Spine and Extremities, 995
Otitis Media, die Radikaloperation des Ohres ohne Gehorgansplastik bei chronischer Mittelohreiterung, 817
Otology, Atlas of, 1221
Paleopathology, 742
Panárketon, 55
Pancreas, Enfermedades del Higado y del Pancreas, 1804
Paramore, R. H., The Toxaemia of Acute Intestinal Obstruction or Vomiting as a Pathological Force, 743
Pathology, Ribberts Lehrbuch der Allgemeinen Pathologie und der Pathologischen Anatomie, 153
Pathology, Surgical, 2075
Pearl, R., Introduction to Medical Biometry and Statistics, 232
Pediatrics, 1885
Pediatrics, Children's Diseases for Nurses, 1885
Pediatrics, Handbuch der Kinkerheilkunde, 913, 2075
Pediatrics, Lehrbuch der Kinderheilkunde für Aerzte und Studierende, 914
Pediatrics, Management of the Sick Infant, 1463
Pediatrics, Traité de Pathologie médicale et de Thérapeutique appliquée XXIV, Pédiatrie, Tome I., 493
Perrin, M., Les Sécrétions Internes, 652
von Pfaundler, M., Handbuch der Kinderheilkunde, 913, 2075
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Pharmacy, Bulletin de la Fédération Internationale Pharmaceutique, 493
Phillips, T. G., Fundamentals of Organic and Biologic Chemistry, 1221
Physical Examination and Diagnostic Anatomy, 1292
Physiology, Protoplasmic Action and Nervous Action, 1291
Pickett, S. E., The American National Red Cross, 1385
Pinkus, F., Die Syphilis, 1804
Pituitary Body, Concerning Certain Ocular Aspects of Disorders of, (1923 Bowman Lecture), 1884
Porter, L., Management of the Sick Infant, 1463
Pouisson, E., A Text-Book of Pharmacology and Therapeutics, 914
Pratt, F. J., Intranasal Surgery, 1636
Pratt, J. A., Intranasal Surgery, 1636
Pregnancy, Protecció a la dona grávida, 571
Preyer, W., Die Seele des Kindes, 995
Proctology, Diseases of Rectum and Colon, 54
Proctology, Manual of, 650
Prohibition, Alcohol and Prohibition in Their Relation to Civilization and Art of Living, 570
Protozoology, Human, 1718
Prym, P., Die therapeutischen Röntgenbestrahlungen vom pathologischanatomischen Standpunkte, 2142
Psychology, Constructive Conscious Control of the Individual, 817
Psychology, Dynamic Problems in, 54
Psychology, die Seele des Kindes, 995
Public Health Administration, Elements of, 415
Public Health Campaign, Evolution and Significance of, 152
Public Health in the United States, 152
Radium, Effects of, upon Living Tissues, 1385
Raper, H. R., Radiodontia (Dental Radiography and Diagnosis), 1385
Read, C. A., A Manual of Nursing Procedures, 1637
Rectum, Cancer du Rectum, 1636
Red Cross, American National Red Cross, 1385
Reid, E. P., A Manual of Nursing Procedures, 1637
Relmann, S. P., Excursions into Surgical Subjects, 328
Respiration, les Syndromes Respiratoires, 743
Retina, la Circulation rétinienne, 1463
Richards, G. L., The Medical Work of the Near East Relief, 1566
Rigg, G. B., The Pharmacists' Botany, 1385
Robertson, T. B., Chemical Basis of Growth and Senescence, 651
Roentgenology, Clinical Roentgenology of Diseases of the Chest, 914
Roentgenology, Digestive Disturbances in Infants and Children Roentgenologically Considered, 232
Roger, G. H., Nouveau traité de Médecine; Fascicule XIII, 1718
Röntgentherapie, 1717
Röntgentherapie, Handbuch, 328, 2142
Rossmoore, E. E., Federal Income Taxes; Principles and Practice, 571
Roussy, G., L'État Actuel du Problème du Cancer, 1804
Rudolf, R. D., Notes on Medical Treatment of Disease, 415
Ruhräh, J., Dietetics for Nurses, 2142
Russell, R. H., Papers and Addresses in Surgery, 1384
Sabouraud, R., Maladies du Cuir Chevelu, 1804
Sadtler, S. S., Allen's Commercial Organic Analysis, 816
Sandu, D. V., Indian Therapeutics (for Medical Practitioners), 232
Scalp, Maladies du Cuir Chevelu, 1804
Schellberg, O. B., Colonic Therapy in the Treatment of Disease, 1068
Schlossmann, A., Handbuch der Kinderheilkunde, 913, 2075
Schmidt, H. E., Röntgentherapie, 1717
Schröder, P., Introduction to the Histology and Histopathology of the Nervous System, 816
Schwalbe, J., Diagnostische und Therapeutische Irrtümer und deren Verhütung, 1292, 1637, 1463
de Schweinitz, G. E., The 1923 Bowman Lecture, Concerning Certain Ocular Aspects of Pituitary Body Disorders, 1884
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Sergent, E., Les Syndromes Respiratoires, 743
Sergent, E., Traité de Pathologie Médicale et de Thérapeutique Appliquée XXIV, Pediatrie, Tome I., 493
Sex Education, Parents and Sex Education, 1385
Sexual Hygiene, Hygiene of Marriage, 153
Shaffer, N. M., Selected Essays on Orthopaedic Surgery, 2074
Ship Sanitation, Manual on Ship Sanitation, 1384
Siemens, H. W., Einführung in die Allgemeine und Spezielle Vererbungspathologie des Menschen, 570
Skin, Diseases of, 743
Slade, C. B., Physical Examination and Diagnostic Anatomy, 1292
Smith, S. C., Heart Records, Their Interpretation and Preparation, 651
Sonntag, E., Verletzungen und chirurgische Krankheiten der unteren Extremität, 1637
Spaulding, E. R., An Experimental Study of Psychopathic Delinquent Women, 1384
Spine, Surgery of Spine and Extremities, 995
Statistics, Introduction to Medical Biometry and Statistics, 232
Stevens, A. A., Manual of Practice of Medicine, 232
Stone, W. J., Blood Chemistry, 571
Surgery, die Chirurgie des Anfängers, 817
Surgery, Excursions into Surgical Subjects, 328
Surgery, Handbook of, 914
Surgery, Operative, 1635
Surgery, Papers and Addresses in, 1384
Surgery, Verletzungen und chirurgische Krankheiten der unteren Extremität, 1637
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Syphilis and Genito-Urinary Diseases, 1464
Syphilis, die Syphilis, 1804
Syphilis, Handbuch der Serodiagnose der Syphilis, 1804
Syphilis, Laboratory Diagnosis of, 493
Syphilis, Marriage and, 571
Syphilis, Serum Diagnosis of; Wassermann and Sigma Reactions Compared, 328
Taliaferro, W. H., Human Protozoology, 1718
Taylor, R. H., Surgery of Spine and Extremities, 995
Teeth, Diet and Health, 1463
Therapeutic Research Committee of the Council on Pharmacy and Chemistry of the American Medical Association, Investigations of, 1986
Therapeutics, Indian Therapeutics (for Medical Practitioners), 232
Therapeutics, Lexikon der gesamten Therapie des praktischen Arztes, 415
Therapeutics, Notes on Medical Treatment of Disease, 415
Thewlis, M. W., Geriatrics, 1717
Thoma, K. H., Teeth, Diet and Health, 1463
Thorax, Clinical Roentgenology of Diseases of the Chest, 914
Thyroid, le Cancer Thyroïdien, 1804
Todd, J. C., Clinical Diagnosis by Laboratory Methods, 493
Tuberculosis, die Klinik der beginnenden Tuberkulose Erwachsener, 1291
Tuberculosis, die Lungenphthise, 492
Tuberculosis, Handbuch der gesamten Tuberkulose-Therapie, 1384
Tuberculosis, Inégalité Pupillaire et Tuberculose Pulmonaire, 55
Tuberculosis, Problems in, 2074
Tuberculosis, Pulmonary, Its Diagnosis and Treatment, 995
Urea, the Chemistry of, 1141
Urrutia, L., Enfermedades del Higado y del Páncreas, 1804
Uveal Tract, la Tubercolose du Tractus Uvéal, Infection et Superinfection, 1385
van Boeckel, L., L'Encéphalite Léthargique; ses Particularites en Belgique, 1069

BOOK NOTICES—Continued

Vecki, V. G., Alcohol and Prohibition in Their Relation to Civilization and Art of Living, 579
Vertebrates, Membres et Ceintures des Vertèbres Tétrapodes, 233
Vialleton, L., Membres et Ceintures des Vertèbres Tétrapodes, 233
Vignes, H., Physiologie Obstétricale, Normal et Pathologique, 651
Vital Statistics, Elements of, in Their Bearing on Social and Public Health Problems, 1803
Vital Statistics, Principles of, 232
Voice, Hygiene of, 2142
Voorhees, I. W., Hygiene of the Voice, 2142
Wallace, J. S., Oral Hygiene, 1464
War, Krieg und Frieden im Lichte der Medizin, 650
Watson, L. F., Hernia, 1141
Weather and Disease, die geopsychischen Erscheinungen, Wetter und Klima Boden und Landschaft in ihrem Einfluss auf das Seelenleben, 1506
Werner, E. A., The Chemistry of Urea, 1141
Wessler, H., Clinical Roentgenology of Diseases of the Chest, 914
Whiting, A. D., Bandaging, 1292
Wilder, R. M., Primer for Diabetic Patients, 572
Wilson, E. B., Physical Basis of Life, 572
Winslow, C. E. A., Evolution and Significance of Modern Public Health Campaign, 152
Workmen's Compensation Acts in the United States, 742
Workmen's Compensation, Study of Workmen's Compensation, Insurance Laws and Service, Monopoly or Competition, 1291
Young, J., A Combined Text-Book of Obstetrics and Gynaecology, 1229
Youngken, H. W., Pharmaceutical Botany, 233
Zondek, H., Die Krankheiten der Endokrinen Drüsen, 652
Zoology, Disease in Captive Wild Mammals and Birds, 1717
Zweig, W., Lehrbuch der Magen-und Darmkrankheiten, 743

C

CACTUS spine pseudotubercles, [Warthin & Davis] 821—ab
CADUCEUS, where shall we place it? [Mendel] 648—C
CAFFEIN glycosuria, [Gautier] 1083—ab
  paralysis in frogs, [Fredericq & Radelet] 1230—ab
CAIRO SCHOOL OF MEDICINE, replacement of British by Egyptian teachers at, 806
CAJAL, trouble and honor for, 1878
CALCIUM deposits in epiphyses and skin, [Tisdall & Erb] 575—ab
  action of, [Günther & Heubner] 1902—ab
  deposits of, around joints, [Stegemann] 342—ab
  diuretic action of, [Barinetti] 425—ab
  in Blood: See Blood calcium
  in treatment of asthma, hay-fever and eczema, [Pottenger] 156—ab
  metabolism and action, [Jansen] 1902—ab
  metabolism and phosphorus metabolism, [Telfer] 2086—ab
CALLUS grafts, growing power of transplanted periosteal callus, [Klinkerfuss] 2146—ab
CALORIES, calculating, [Du Bois] 1224—ab
CAMPHOR, intravenous injections of, [Schilling] 167—ab
  liniment, poisoning due to, [Lang] *2119
  poisoning, fatal case of, [Clark] 1399—ab
CANCER: See also Epithelioma; Sarcoma; Tumor, and under names of organs and regions
CANCER among African natives, [Leipoldt] 1400—ab
  and pregnancy, [Odermatt] 1900—ab
  as disease of organism, 317
  aspiration metastasis of, [Lino] 753—ab
  biologic research on serum in, before and after injections of radium emanation, [Fischer & Kotzareff] 163—ab
  blood phosphorus in, [Zerner] 1309—ab
  body fluids in, [Kotzareff & Weyl] 584—ab
  Boyksen's test for, [Harke] 831—ab
  cause of death in, [Holzbach] 507—ab
  cells, adsorption by, [Carra] 166—ab
  cells, biology of, [Erdmann] 345—ab
  cells, metabolism of, [Wiechmann] 1575—ab
  cells, respiration of, [Neuschloss] 665—ab
  contagiousness of, [Fiessinger] 1401—ab
  control crusade, 1706
  control in Belgium, 1625
  control in British Empire, 805, 1793
  control, education of public in, 484, [Bloodgood] 1299—ab
  control, Spanish Anticancer League, 1376
  curability of, [Werner & Borchard] 587—ab
  "cures," exploiting cancer sufferer, 2054—E
  diffuse pruritus as premonitory symptom of, [Küttner] 2094—ab
  electrochemical diagnosis of, [Walterman] 346—ab
  etiology, acute myelocythemia and chloroma, [Goodall & Alexander] 825—ab
CANCER, experimental, from continued irritation, [Burckhardt & Müller] 427—ab
  experimental, metastasis with, [de Jongh] 668—ab
  experimental, pathogenesis of epithelial growths, [Yamagiwa & Murayama] 2082—ab
  fever in carcinoma, [Briggs] 495—ab
  food and cancer evolution, [Ludwig] 1305—ab
  formation of, [Bauer] 345—ab, [Bierich] 930—ab
  gas metabolism in cancer rats, [Händel & Tadenuma] 1232—ab
  glycolytic action of, [Braunstein] 1902—ab
  growth, source of material for, [Freund & Kaminer] 428—ab
  hairs, Schridde's, [Friedrich] 170—ab
  heredity in, [Van Dam] 507—ab
  history of, [Razetti] 1484—ab
  immunization with attenuated tumor substance, [Caspari] 1309—ab
  in Amsterdam, [Deelman] 74—ab
  in Egypt, [Dolbey & Mooro] 1400—ab
  in gunshot scar, [Just] 666—ab
  in Hongkong, Shanghai and Bermuda, [Hoffman] 490—C
  in Marseilles, frequency of, 1457
  in Prague, prevention of, 2133
  in Virgin Islands, [Van Gaasbeek] 750—ab
  irradiation of, [Opitz] 428—ab
  L. Duncan Bulkley and "Cancer," [Hulett] 1285—C
  lactic acid in, [Glaessner] 1743—ab
  melanotic, metastasis of, after 18 years, [Webb-Johnson & Macleod] 1150—ab
  metabolism of irradiated cancer, [Piccaluga] 753—ab
  metastatic basal cell carcinoma from skin, [Finnerud] *775
  mouse, roentgen rays induce resistance to, [Murphy & others] 62—ab
  origin and nature of, 731
  periodic familial cancer, [Swoboda] 1309—ab
  prevalence of, [Berencsy & Wolff] 1309—ab
  prison statistics of, [Hoffman] 1629—C
  prophylaxis of skin cancers, [Du Bois] 503—ab
  proteins in serum in, [Kennaway] 2087—ab
  publicity in, [Saltzstein] 2140—ME
  radiotherapy in, 1373, 2131
  radiotherapy in, silver salt electrolysis as adjunct to, [Battles] 1154—ab
  research, fund for, 1276
  research in Belgium, 48
  research, international, 137
  research, new lines of progress in, 35—E, [Burrows] 323—C
  roentgen, diathermy in, [Bordier] 1402—ab
  roentgen and radium treatment of malignant tumors, [Kurtzahn & others] 1658—ab
  roentgen rays in, [Bittmann & Fruhauf] 1010—ab, [Kok] 1484—ab
  serum in, [Sabrazès & Muratet] 584—ab
  Society, Austrian, prize of, 1708
  statistics, 905
  tar, [Fabry] 666—ab
  tar accelerated, in rabbits, [Bittmann] 1010—ab
  tar, cancer producing factor in tar, [Kennaway] 1572—ab
  treatment by autoserum, [Zerner] 1088—ab
  treatment, destruction before removal in, [Wyeth] 1643—ab
  treatment in period of complications, [Renaud] 1231—ab
  treatment, result of delay in, [Simmons & Daland] 577—ab
  treatment, surgeon and radiologist in, [Marchbanks] 1390—ab
  treatment with quinin in, [Goyena] 1085—ab
CANNED FOODS in relation to health, 642
CANNED HEAT, 1139, 1383
CAPILLARIES: See also Pulse, capillary
CAPILLARIES, contractility of, [Policard] 425—ab
  endothelia of, as migrating cells, [Herzog] 1658—ab
  exaggeration of capillary network of skin, [Thomson] 421—ab
  microscopy of, in pregnancy, [Baer & Reis] *526
  research on, [Secher] 1090—ab
  restriction of rate of flow and interchange in, by vasoconstrictor drugs, [Douglas] *381
CAPON SPRINGS WATER [Hare] 1138—C
CARBOHYDRATE deprivation, effects of, on pancreas function, [Southwood] 247—ab
  digestive disturbance from, [Roux & Golfon] 1481—ab
  effect of diets deficient in preformed carbohydrates on nutrition, [Osborne & Mendel] 1224—ab
  metabolism and pancreas, [Toenniessen] 930—ab
  metabolism studies, [Harrop & Benedict] 1892—ab
  tolerance for, [Bodansky] 578—ab
CARBON, fate of injected carbon particles, [Wislocki] 819—ab
  Dioxid: See under Air, Alveolar
CARBON monoxid, approval of "self-rescuer" by Bureau of Mines, 1187—ab
  monoxid asphyxia, [Forbes & others] 1296—ab
  monoxid asphyxia, relief of intracranial symptoms in, 1783—E
  monoxid asphyxiation from motor exhaust, [Emerson] 227—C
  monoxid causes death of fetus, [Phillips] 659—ab
  monoxid, danger from illuminating gas, 645
  monoxid, effect of, on different persons, 330—MI
  monoxid poisoning and oxygen treatment, [Panis & Salmon] 1482—ab
  monoxid poisoning, death from pneumonia after inhalation of exhaust gas, 58—MI
  monoxid poisoning from exhaust gas, [Harbitz] 508—ab
  monoxid poisoning, multiple neuritis following, [Wilson & Winkleman] *1407
  monoxid, prevention of poisoning from exhaust gases, 911
  Tetrachlorid: See also under Uncinariasis
  tetrachlorid, behavior of, in body, 1268—E
  tetrachlorid, liver function improved by, [Bose & Mukerji] 1572—ab
  tetrachlorid, pharmacology of, [Chopra & McVail] 64—ab
  tetrachlorid poisoning, [Phelps & Hu] *1254
CARBUNCLE in kidney, [Colmers] 1157—ab
  roentgentherapy for, [Lewis] 241—ab
  spontaneous rupture of spleen following, [Diehl] *951
  treatment with cautery, 177—ab
  treatment with magnesium sulphate, [Morison] 1895—ab
CARCINOMA: See Cancer
CARDIOSPASM, diagnosis and treatment of, [Vinson] *859
  dilatation of esophagus in, [Vinson] 1227—ab
CARDIOVASCULAR DISEASE and abdominal symptoms, [Lichty] 922—ab, 1946—ab
  bronchial asthma complicating, [Harkavy] *100
  cardiovascular tests inefficient, [Seham & Seham] 331—ab
  etiology of, [Barnes] 1571—ab
  insufficiency of circulation in children, [Schiff] 1405—ab
  prognosis in, [Cotton] 1150—ab
  prophylaxis of, [Barnes] 155—ab
CARNEGIE FOUNDATION, report of, 803
CARNEGIE HERO FUND to roentgenologist, 313
CAROTID BODY, tumor of, [Royster] 1398—ab
CAROTINEMIA, case of, [Niehaus] *547
CARRIERS: See under names of diseases as Diphtheria, carriers; Typhoid, carriers, etc.
CARVACROL and thymol, vermicidal action of, [Caius & Mhaskar] 161—ab
CASCARA, Tablets Cascara Comp. (Killgore's) 812—P
CASE'S RHEUMATISM CURE, 145—P
CASTRATION, endocrines and sex activity, [Quaranta] 1154—ab
CATARACT, congenital, treatment of, 148
  diabetic, in child, [Strouse & Gradle] *546
  extraction, technic in, [Hogshead] 1388—ab
CECUM, ptosis and torsion of, [Araya] 755—ab
  shortening, [McLean] 336—ab
CELLS, nature of cell impulse, [Mackenzie] 1228—ab
  respiration, action of serum on, [Neuschlosz] 1741—ab
  stimulation and permeability of, [Ebbecke] 930—ab
CEPHALEMATOMA of new-born, aspiration of, [Lankford] 63—ab
CEREBELLUM in relation to muscular action, [Leiri] 832—ab
  cerebellar symptoms produced by suprasellar tumors, [Bailey] 918—ab
  surgery, method of approaching cerebellum, [Eckstein] 1731—ab
CEREBROSPINAL FLUID, Arsenic in: See under Arsenic
  absorption spectra of, [Schlonoya] 1992—ab
  barrier between blood and, [Stern] 663—ab
  colloidal benzoin reaction, [Hicks & Pearce] 1081—ab
  colloidal gold and mastic tests, [Wassermann] 1296—ab
  colloidal gold reaction, [Bloch & Biberfeld] 1740—ab
  colloidal gold reaction in disseminated sclerosis, [Adams] 501—ab
  demonstrating spirochete in, [Wile & Kirchner] 822—ab, 1631
  effect of insulin on reducing substance in, [Kasahara & Uetani] 1816—ab
  glucose in, [Fontanel & Leuller] 1083—ab
  in nutritional disturbances, [de Capite] 249—ab
  in parturients, [Pérez & others] 250—ab
  inorganic phosphorus content of, [Cohen] 2087—ab
  modification of Bass hematocytometer for counting blood or spinal fluid, [Johns] *1045
  passage of bismuth into, in syphilis, [Jeanselme & others] 1304—ab
  passage of iodids into, [Cohen] 824—ab
  pathologic physiology of cerebral ventricles in syphilis, [Cestan & others] 1736—ab

CEREBROSPINAL FLUID, pressure in, artificial modification of, [Celasco] 69—ab
pressure, raising of; effect on lumbar puncture headache, [Solomon] *1512
pressure of, significant in head injuries, [Thorning & Lapat] 1650—ab
subarachnoid blocking of, [Ayer] 242—ab
Wassermann Reaction in: See under Wassermann Reaction
CEREBRUM: See Brain
CESAREAN SECTION, [Häggström] 1904—ab
extraperitoneal, [Davis] 1728—ab
low cervical, place of, [Hirst & van Dolsen] *1163
premature, [Caraven] 1654—ab
transperitoneal cervical, [Phaneuf] 499—ab
without mortality, [O'Shea] 1397—ab
CHALAZION, ossification in, [Franklin & Cordes] *519
CHANCRE excision, status of, 148
of tonsil, [Ramadier] 927—ab
CHANCROID, influence of soft chancre on syphilis, [Haxthausen] 239—ab
isolation of Ducrey bacillus from smegma of normal men; preliminary report, [Brams] *1166
serologic diagnosis and treatment of, [Reenstierna] 584—ab
serpiginous, tuberculin treatment of, [Baliña & Quiroga] 929—ab
CHARCOT'S DISEASE: See Sclerosis, multiple
CHAULMOOGRA and hydnocarpus oils, comparative value of ethyl esters of, [Read] 1082—ab
antiseptic power of, [Schöbl] 1149—ab
Canal Zone grows chaulmoogra trees, 803
study of oils in chaulmoogra group, [Perkins & Cruz] 1080—ab
therapeutic experiments with, [Schöbl] 1080—ab
CHEMICAL FOUNDATION wins, 130—E
CHEMICAL SOCIETY Prize Essays, 312
CHEMOTHERAPY, limitations of, 969—E
CHENOPODIUM oil, precaution in using, [Cheinisse] 1231—ab
illness after treatment with, [Muench] *33
CHEST: See Thorax
CHICAGO'S health in 1923, 133
CHICKENPOX, and herpes zoster, [Bókay] 1404—ab, [Netter] 2087—ab
and smallpox, blood in, [Hoffmann] 158—ab
bed isolation for, and measles, [Harries] 1229—ab
diagnosis of smallpox and, [Painton] 245—ab
masked, [Wieland] 1405—ab
prophylaxis of, with convalescents' serum, [Weech] *1245, [Schmidt] 2093—ab
syphilitic eruption determines seat of lesions in, [Tillett & Rivers] 2082—ab
virus of, in blood, [Rivers & Tillett] 335—ab
CHILBLAINS, roentgen-ray treatment of, [Kroll] 1741—ab
CHILDREN: See also under Infants; Schools
CHILDREN, American, compared with English, 1561
anorexia in, [Clarke] 1227—ab
bill for protection of, 805
declaration of rights of, 1456
defective, educating, 1374
height and weight of school children, 1798
hygiene, suggestions from school inspection, [Loir & Legagneux] 584—ab
Malnutrition: See under Nutrition
mental and moral development of, and its hygiene, [Gadelius] 74—ab
mortality of, and higher education of parents, [Lennox] 745—ab
mortality of, in physicians' families, 635—E
neuropsychiatry in treatment of, [Roubinovitch & others] 1655—ab
welfare, child health demonstration in far west, 1873
welfare in Brazil, 140
welfare in Spain, 732
welfare, outings for children, 1211
welfare, school of puericulture, 1133
CHINA, ancient, status of physicians in, 889—ab
CHINESE, blood pressure of normal Chinese, [Cadbury] 64—ab
old Chinese medical fable, 412
CHIROPRACTORS and life insurance examinations, [Camp] 738—C
and physicians of New York have not "compromised," 1366—E
chiropractor—diphtheria—manslaughter, 1203—E
conviction of, 1465
deaths from diphtheria in family of, [Ravenel] 568—C
"disease" and "diagnosis," 744—M
law violated by,—sentence to hard labor, 494—M
lo, the poor chiropractor, 1613—E
CHLORAL hydrate, color test for chloroform and, [Ross] 579—ab
CHLORID metabolism as gage of resorption of effusions, [Deiss] 2091—ab
CHLORIN and respiratory tract diseases, 971—E
as a therapeutic agent in certain respiratory diseases, [Vedder & Sawyer] *764
for colds, 2079
CHLOROFORM Anesthesia: See Anesthesia, chloroform
CHLOROFORM, burn of cornea, 1883
color test for chloral hydrate and, [Ross] 579—ab
in gastric stenosis, [Loeper & others] 1153—ab
poisoning, [Stander] 1147—ab
CHLOROMA and acute myelocythemia, [Goodall & Alexander] 825—ab
CHLOROSIS, decreasing incidence of, 210—E, [Weissenbach] 2088—ab
severe, [Isaacs] 656—ab
CHOLAGOGUES, 1867—E
CHOLECYSTECTOMY: See Gallbladder excision
CHOLECYSTITIS: See Gallbladder inflammation
CHOLECYSTOCOLOSTOMY with tube and possibility of valve formation, [Wise] *1936
CHOLELITHIASIS: See Gallbladder calculus
CHOLESTEATOMA of third ventricle, with bilateral Argyll Robertson pupils, [Ford] *1046
CHOLESTEROL, absorption of, [Sano] 1157—ab
in blood and bile, [Barat] 1234—ab
metabolism of, [Rémond & others] 1996—ab
rôle of, in fat metabolism, [Bloor] 1891—ab
CHOLIN and blood coagulation, [Zunz & La Barre] 926—ab
CHONDRIOSOMES: See Mitochondria
CHONDRITIS, infectious intervertebral, [Báron] 2149—ab
CHORDOMA, malignant sacrococcygeal, [Andler & Schmincke] 589—ab
malignant spheno-occipital, [Burrow & Stewart] 582—ab
CHOREA, etiology and treatment of, [Salomon] 1007—ab
intraspinal autoserotherapy of, [Rohr] 1999—ab
CHORIO-ANGIOMA of placenta [Strachan] 246—ab
CHOROID, sarcoma of; unusual complication of diabetes mellitus, [Guion & Berens] *1024
CHOROID PLEXUS and uremia, [Monakow] 663—ab
effect of methyl violet on permeability of, [Smith & Waddell] 1813—ab
in acute intoxications, [Siengalewicz] 1152—ab
CHVOSTEK'S sign in childhood, [Eckert] 1487—ab
in older children, [Pogorschelsky] 829—ab
CHYLURIA, filarial, [Diamantis] 827—ab
nonparasitic, report of case of, with cystoscopic findings, [Welfeld] *110
CICATRIX, bone growth in bladder incision wound, [Boss] 1405—ab
CINCHOPHEN, antiphlogistic effects of, [Hanzlik & Tainter] 336—ab
idiosyncrasy to, [Scully] *623
poisoning, case of severe allergic reaction, [Barron] *2010
CITRATE, experimental study of toxicity of sodium citrate, [Joannides & Cameron] *1187
sodium citrate, action of, on stomach and intestines, [Love] 921—ab
sodium citrate, hemostasis with, [Renaud & Juge] 1303—ab
sodium citrate, pharmacology of, [Love] 336—ab
CITROPHAN and Herman Rubin, [Hyman] 911—C, [Goldwater] 999—C
another "fat cure" nostrum exploited to medical profession and public (Citrophan), 734—P
CLAIRVOYANCE, case of, [Neumann] 1305—ab
CLAMP, hemostatic, for rapid excision of goiter, [Tennant] *630
CLASMATOCYTES and tumor cells in mouse sarcoma cultures, [Lewis & Gey] 157—ab
CLAUDICATION, intermittent, surgery of, [Seidlinger] 1486—ab
CLAVICLE operations, new incision for, [Soutter] *1179
osteomyelitis of, [Bercovitz & Chu] *2032
CLIMATE: See also Altitude; Meteorology; Weather
CLIMATE, North Sea, action of, [Haberlin & others] 168—ab
CLOTHING and food as factors in school life, 1458
COCAIN: See also under Anesthesia
COCAIN and its substitutes, 414—ME
cocain spray, hyperesthetic rhinitis, 1286
toxicity of, [Watson-Williams] 161—ab
COCCULUS alkaloids, 2 new cocculus alkaloids, [Ohta] 581—ab
COCCYX, removal of, after injury, [Hirst & Wachs] 1144—ab
tuberculosis of os coccygis, [David] *21
COD-LIVER OIL and vitamin A, [Poulsson] 1231—ab
antirachitic effect of, [Hess & Weinstock] 575—ab
Cod Liver Oil—Squibb, 1123
metabolism of, by diabetics, [Mottram] 1400—ab
saponified, [Steenbock & others] 578—ab
taking cod liver oil, [Block] 1382—C
COFFEE, Prescott coffee report, [Osborne] 2137—C
COG-WHEEL MOTOR PHENOMENON, [Bing] 662—ab
COLD, effect of, on blood sugar, [Riddle & Honeywell] 496—ab
effect of working in cold and heat, not accidental, 1222—MI
COLDS, blood platelet variation in, [Bannerman] 1081—ab
chlorin gas for, 2070
epidemiological survey of, 483
filter passing organism not cause of, [Robertson & Groves] 1648—ab
relation of, to diabetes, [John] 1226—ab
study of acute infections of throat and respiratory system, [Smiley] *540
treatment of, in tuberculous subjects, [Gunter] 1399—ab
COLITIS, [Strauss] 505—ab
chronic ulcerative, [Helmholz] 239—ab
chronic ulcerative, surgical treatment of, [Kroglus] 829—ab
mucous, [Went] 2091—ab
therapy of, [Lieb] 1227—ab
with edema in infants, [Müller & Paul] 931—ab
COLLAR OF VENUS; melanoleukoderma colli of syphilis, [Goodman] *701
COLLARGOL, effect of injecting into vas deferens, [Brams] 62—ab
COLLECTIONS, Merchants Protective Agency, Inc., [Owen] 1630—C
COLLEGE OF PHYSICIANS AND SURGEONS, Boston, 1140
COLLODION SACS, preparation of, [Lumière & Chevrotier] 1653—ab
COLLOIDAL GOLD TEST: See under Cerebrospinal Fluid
COLLOIDS, chemistry of, and medicine, [Pauli] 587—ab
COLOBOMA of macula lutea, [Janku] 253—ab
COLON, arrested development of, [Rhodes] *1752
ascending, dilatation of, [Grégoire] 340—ab
bleeding in, [Vervloet] 1010—ab
cancer of, 48
megacolon, familial, [Dalla Valle] 2089—ab
megacolon, pathogenesis of, [Romani] 928—ab
megacolon, total resection of colon in, [Huber] 1825—ab
ptosis, diagnosis and treatment of right coloptosis, [Quain] 238—ab
right, torsion volvulus of, [Twyman] 238—ab
tumor, malignant myoma of, [Scott] 498—ab
COLOR association with sounds, [Estapé] 1403—ab
color blindness, 740
COMA, Diabetic: See Diabetes
COMPLEMENT, Fixation: See also under Tuberculosis; Wassermann Reaction
fixation, action of lysins of serum, [Poyarkoff] 1898—ab
fixation and instability of colloids, [Sachs & others] 588—ab
CONGO, birth rate in, 986
hospital ship on, 986
CONGRESSES: See under Societies at end of letter S
CONJUNCTIVITIS, follicular, [Arboleda] 250—ab
Parinaud's, with demonstration of leptothrix of Verhoeff, [Lemoine] *537
severe edematous, from powdered orris root, [Roy] *208
vernal, cause and treatment of, [Fort] 1812—ab
CONSTIPATION: See also Intestines, stasis
CONSTIPATION, effects of stagnation in ascending colon, [Gray] 1146—ab
manipulation for relief of, [Whitney] *33
spastic, differential diagnosis of, [Hannemann] 1742—ab
treatment of, in tuberculosis, [Spector & Lardmore] 1145—ab
CONSTITUTION and fitness, 794—E
human, studies in; clinical anthropometry, [Draper & others] *431
CONSUMPTION: See Tuberculosis, Pulmonary
CONTAGIOUS DISEASES: See Infectious diseases
CONTRACEPTION: See Birth Control
CONTRACT, agreement not to practice within 20 miles, 1387—MI
breach of, by plastic surgeon, 1885—MI
CONTRACTURE, Volkmann's ischemic, pathogenesis of, [Soubeyran & Lenormand] 1997—ab
CONVALESCENCE, some problems of slowly convalescent or half-sick child, [Miller] 1811—ab
CONVERSATION, human interests, 1050—E
CONVULSIONS, early, in epileptics and in others, [Patrick & Levy] *375
in infancy, [Vivaldo] 664—ab
intracranial pressure changes during, [MacDonald & Cobb] 582—ab
COOLIDGE, President's disapproval of federal subsidies to state governments, 396—E
COPPER, catalytic action of minute amounts of, in destruction of antiscorbutic vitamin in milk, [Hess & Weinstock] *952
salts, treatment of adenitis with, [Carnot & Froment] 1402—ab
sulphate necrosis, [Cole] 1890—ab
CORNEA: See also Keratomalacia

CORNEA, arc of, in young adults, [Jöel] 1007—ab
chloroform burn of, 1883
sensitiveness of, [Kant & Hahn] 665—ab
ulcer, exophthalmic goiter as cause of, [Hinton] 1645—ab
CORPORATION, employment of physician for employee of, 1720—Mi
CORPSES, virulence of germs in, [Fiorito] 1656—ab
CORPUS LUTEUM and menstruation, [Cotte] 662—ab, [Schickelé] 1304—ab
Corpus Luteum—Lederle, 391
extirpation of, [Ostrell] 1009—ab
extract, dosage of, 491
function of, [Matsuno] 588—ab
hemorrhage of, [Schickelé] 1304—ab, [Eick] 1309—ab
CORSET, special, for back conditions, [Porter & Levin] *32
CORYZA: See Colds
COSMETICS, dermatoses due to, [Cole] *1909
COSTA'S REACTION in blood, [Bagliani] 341—ab
COTTON SEED poisoning, pathology of iron deficiency and, [M'Gowan] 1734—ab
CRAMPTON BILL passed by House, 1978
industrial alcohol users protest, 1055
CRANIUM, fracture of, [Huer] 1467—ab, [Davis] 1471—ab
bathrocephaly and clinocephaly, [Backman] 1904—ab
fracture, pneumoventricle of cerebrum following, [Teachenor] 241—ab
injuries, classification and management of, [Rodman & Neubauer] 1645—ab
injury of, [Vaughan] 499—ab
intelligence and cranial capacity, 2060
Intracranial Pressure: See Intracranial Pressure
percussion, [Thurzó] 666—ab
percussion, tympany of skull in deforming osteitis, [Vogl] 1658—ab
shape of skull and heredity, [Fischer] 345—ab
sutures, pathologic closure of, [Merlini] 68—ab
sutures, premature obliteration of, [Reyher] 1487—ab
treatment of defects in, [Käfer] 1155—ab
tumor, recovery under roentgen-ray treatment, [Heidema] 831—ab
vascularity of, and intracranial disease, [Elsberg & Schwartz] 1297—ab
CREATININ test for renal function, [Major] 655—ab
formation of, in brain, [Hammett] 1816—ab
in Blood, in Urine: See under Blood; Urine
CREDIT BUREAU, 398
CREOSOTE causes epithelioma of skin, [Cookson] 1228—ab
Mistura Creosote Comp. (Killigore's), 812—P
CRETINISM, basal metabolism in diagnosis and treatment of, [Talbot & others] 1008—ab
new views on, [Pinkbeiner] 1658—ab
CRIME, criminal responsibility, 1621, 2061
criminal responsibility bill, 1980
criminality in children, [Friedjung] 755—ab
dental opinion in criminal cases, 1623
need of medical observation of child offenders, 1705
CRIPPLES, care of, 896
CRYOGENINE, 1443
CUMMING, SURGEON-GENERAL, honors conferred on, 1057
CUSHIONS, simple substitute for ordinary sandbag in gallbladder surgery, [Judd] *1199
CUTIS VERTICIS GYRATA, [Sainz de Aja & Bravo] 822—ab, 1998—ab
CYST: See also under names of organs and regions
CYST, unusual, [Greeley] *303
CYSTINE, substituting taurine for, does not retard growth, [Mitchell] 1733—ab
CYSTINURIA, 130—E
familial, [Harris] 2147—ab
CYSTITIS, hemorrhagic, in young children, [Cirillo] 1230—ab
CYSTOSCOPY, cinematoscopia, [Stutzin] 757—ab
in presence of pus and blood, [Wardill] 825—ab
CYSTOSTOMY: See Bladder surgery
CZECHOSLOVAKIA, sanitary and public health conditions in, 224

D

DAIRY BUREAU, Committee on Agriculture approves establishment of, 1207
DANVAL affair, 2062
DAWSON SPRINGS H. AND H. WATER, 989—P
DAYLIGHT SAVING TIME, 1282
DEAF MUTES, congress of, 318
DEAFNESS from syphilis, [Blue] 1389—ab
disease of Smetana, the musician, [Heveroch] 2094—ab
in school children, 2134
roentgentherapy in, [Richardson] 1815—ab
treatment of, [Kerrison] 1894—ab
DEATH from lack of medical treatment no defense against charge of homicide, 154—Mi
Rate: See Vital Statistics
DEATH, sudden, associated with injection of foreign substances, [Lamson] *1091
sudden natural death, [Haberda] 1903—ab
sudden; thymus, the suprarenals and sudden death, [Horstmann y Varona] 1154—ab
de BEURMANN, death of, 986
DECEREBRATION in man, [Freeman] 1153—ab
DECIDUA, retention of, [Brunner] 827—ab
DECUBITUS, cause of bed-sores, [Reschke] 1156—ab
DEFICIENCY DISEASES: See also under Vitamin
DEFICIENCY DISEASES in ophthalmology and otolaryngology, [Stucky] 1388—ab
DEFORMITIES, operative correction of rachitic curvature, [Martin] 507—ab
growth, causes of, [Braeunig] 1825—ab
DEHYDRATION and anhydremia, 1520—E
and intracranial tension, 1270—E
effects of saline cathartics in conditions of, [Underhill & Kapsinow] *9
experimental, [Keith] 1391—ab
magnesium sulphate and sodium chlorid in intracranial tension, [Fay] *766
postoperative, [Harbin] 1810—ab
DELINQUENCY, juvenile, prevention of, 401
DELIRIUM, movable frame for protecting delirious patients, [Reasoner] *1691
DELIVERY: See Labor
DEMENTIA, questions and cross-examination for one not alienist, 154—Mi
systematic paraphrenia, [Jarrett] 1897—ab
DEMENTIA PRAECOX, [Bumke] 1308—ab
a hereditary degeneration, [Alford] 657—ab
acidophil degeneration in, [Kelly] 2145—ab
analysis and delimitation of, [Claude & others] 1822—ab
brain changes in, [Dunlap] 1075—ab
dangers of psychoanalysis in, [Tramer] 1482—ab
differentiation of schizophrenia, [Claude & Brousseau] 1573—ab
prognosis of psychoses occurring during adolescence, [Henderson] 245—ab
sex development in, [Gibbs] 918—ab
DENGUE, [Shuman] 737—C, [Ashe] 990—C
etiology of, 306—E, [Duval & Harris] 922—ab
organisms in blood in, [Knowles & Gupta] 751—ab
DENTISTRY, dental education and medicine, 1050—E
in France, illegal practice of, 560
DENY, G., death of, 47
DEODORIZED KEROSENE-WELTY, 1265
DERMATITIS, brownish, of legs, [Favre & others] 827—ab
diabetic, insulin in, [Davis & Calhoun] 1393—ab
herpetiformis and thyroid, [Rost] 588—ab
venenata from mah jongg sets, [Levin] *465, [Zeisler] *466
DERMATOLOGY in 1924, [Millian & Brodier] 1482—ab
DERMATOMYCOSIS, achromia parasitaria, [Pardo-Castello & Dominguez] 1076—ab
DERMATOMYOSITIS, [Heyn] *1019
DERMATOSIS: See Skin disease
DERMOTOME, [Hagen] *1533
DESICCATED PARATHYROID SUBSTANCE-WILSON, 1693
DESMOID REACTION: See Stomach, desmoid reaction
D'ESPINE'S SIGN in hilum tuberculosis, [Carroll & Gibson] 1146—ab
clinical value of, [Sieniewicz] 577—ab
DEYL, JAN, death of, 1377
DIABETES INNOCENS, [Campbell] 1990—ab
DIABETES INSIPIDUS, [Gänsslen & Fritz] 588—ab, [Castellano & Schteingart] 1656—ab
hypophyseobasal area in relation to, [Sajous] 1991—ab
pituitary gland in, [Abel & Geiling] 336—ab
DIABETES MELLITUS, and pregnancy, [Lublin] 1087—ab
and glycemia, [Pal] 1743—ab
and neurology, [Binswanger] 1656—ab
and syphilis, [Villaret & Blum] 1004—ab
and tetany, [Motzfeldt] 74—ab
arteries in, [Labbé & Lenfantin] 1821—ab
blood in, total inorganic calcium and phosphorus of, showing peculiar symptom complex, [Smith & West] 1999—ab
caramelized carbohydrates in, 128—E
changes in diabetic clientele, [Joslin] 1887—ab
coma, acute pancreatitis with fat necrosis complicated by, [Rodriguez] *203
coma in, diagnosis of, [Labbé] 1481—ab
coma, differentiation of hyperinsulemia and, [Cowie] 336—ab
coma, fatal case of, without ketosis, [Paddock] *1855
coma, infection, and insulin, [Frissell & Hajek] 1077—ab
coma in, neglected phases of, [McCann] 1642—ab
coma in, treatment of, [Hachen] 1474—ab, [Doijer] 2150—ab
coma, sodium bicarbonate in, [Harris] 1398—ab
complications, diabetic cataract in child, [Strouse & Gradle] *546
complications, glycolytic action of cancer in, [Braunstein] 1902—ab
DIABETES MELLITUS, complications, sarcoma of choroid in, [Guion & Berens] *1024
complications, treatment of, [Wilder] 579—ab
complications, with gangrene in nose, [Bowers] *1325
diabetic patient and his dog, 1502—ab
diet charts for, [McCrudden] *356
dietetic management of, [Allen] 1727—ab
diets in, [Falta] 1089—ab
diets in, new, [Grote] 667—ab
diets in, simple method of prescribing, [Baehr & others] *1509
effect of exercise in, [Himwich & others] 1816—ab
epidemiology of, [Emerson & Larimore] 1887—ab
etiology of, factor in, [Clark] 1301—ab
experimental diabetic acidosis and coma, [Allen] 1476—ab
fasting in; influence on alimentary hyperglycemia, [Beck] 1234—ab
function of liver and pancreas in, [Jones] 156—ab
glycemia as guide to treatment, [Høst] 430—ab
in gallbladder disease, [Rabinowitch] 1646—ab
insulin in, [Jonas] 59—ab, [Chabanier & others] 248—ab, [Barach] *347, [Rowe] 418—ab, [Todd] 421—ab, [Montgomery] 498—ab, [Crawford] 501—ab, [Allan] 750—ab, [Nixon] 751—ab; 1382, [Thomson] 1399—ab, [Sansum & others] 1476—ab, [Viesca y Lobatón] 1483—ab, [Umber & Rosenberg] 1485—ab, [Faber] 1488—ab, [Mahler] 1575—ab, [Falta & others] 1743—ab, [Chabanier & others] 1899—ab, [Von Noorden & Isaac] 1902—ab
insulin, administration of, without blood sugar estimations, [Innes] 751—ab
insulin and surgery of eye in diabetes, [Nicheiatti] 1998—ab
insulin as an investment for patient with, [Fitz & Murphy] *435
insulin in, dangers of interruption of, [Blum & others] 423—ab
insulin, effect of, in diabetic lipemia with lipemia retinalis, [Rowe] *1168
insulin in, hypoglycemia after, [Sevringhaus & others] 59—ab
insulin in diabetic coma, [Foster] 59—ab, [Imrie & Skinner] 530—ab
insulin in diabetic complications, [DeSanctelle] 1471—ab
insulin in tuberculous diabetics, [Labbé & others] 661—ab
insulin reserve, 473—E
insulin in, unreliability of urine findings during insulin treatment, [Hoogslag] 1744—ab
intarvin in, 51—P
juvenile, diet in, [Gray] 1649—ab
metabolism in, [Feyertag] 588—ab
metabolism of cod liver oil in, [Mottram] 1400—ab
mortality from, in 1923, 42
organic acids in urine in, [Star & Fitz] 655—ab
pancreas and diabetic metabolism, [Oertel] 1652—ab
parenteral protein treatment in glycosuria, [Singer] 1089—ab
relation of "colds" to, [John] 1226—ab
significance of glycosuria in gallbladder disease, [Lichty & Woods] 745—ab
studies on, [Petren] 1646—ab
surgical complications, mortality of, [Weeden] *1165
surgical risk in, [Wilder & Adams] 2084—ab
theory of, [Müller & Gänsslen] 1089—ab
treatment, antisyphilitic, [Charlton] 1647—ab
treatment, estimation of total strength as a means for measuring results of, [Fitz & Murphy] 1989—ab
treatment of syphilis, with condition simulating diabetes, [Paullin & Bowcock] *702
treatment, carbon fats in diabetic ketosis of, [Kahn] 495—ab
Wassermann reaction in, [Rockwood & Sanford] 241—ab
DIABETES, PANCREATIC, experimental, [Thiroloix] 163—ab
DIABETES, PHLORHIZIN, influence of insulin on, [Ringer] 578—ab
DIABETES, RENAL, [Labbé] 1996—ab
hypoglycemic symptoms provoked by repeated glucose ingestion in case of, [Gibson & Larimer] *468
DIAGNOSIS, chiropractic, "disease" and "diagnosis," 744—Mi
ectoscopy, [Weisz] 1743—ab
function tests, [Grote] 1903—a.
history and examination basis for, [McPheddran] 1146—ab
mistaken, in infants and children, [Schroeder] *1916
statistics on mortality and necropsies, [Lubarsch] 1308—ab
treatment, biased judgment, damages, diagnosis, 654—Mi
DIAMONDS not discernible by roentgen rays, [Edwards] 66—ab
DIAPHRAGM, congenital deficiency of, [Cutler & Cooper] 1223—ab
eventration of, [Suzuki] 501—ab

DIAPHRAGM excursion, effect of posture on, [Webb & Sevier] 1392—ab
movement of, in lateral posture, [Howard] ★1242, [Webb] 1461—C, [Howard] 1714—C
movements of, and phrenicotomy, [Landé] 1743—ab
DIAPHRAGMITIS, [Betchov] 1899—ab
DIARRHEA, fat, [Mohr & Thaysen] 832—ab
DIASTASE determinations as kidney function test, [Stafford & Addis] 825—ab
DIATHERMY: See also under names of diseases as Paralysis, facial
DIATHERMY, [Reijnders] 832—ab
apparatus for excision of tissue particles, [Donald] 1660—ab
in cancer, [Bordier] 1402—ab
in surgery, [Bianchini] 249—ab
skin resistance in, [Kowarschik] 1309—ab
treatment of injuries during acute stage by, [Holmblad] ★1856
DIATHESIS, Hemorrhagic: See Hemophilia
DIAZO-REACTION in blood, [Leimdörfer] 345—ab
in uremic serums, [Andrewes] 1400—ab
DIBOTHRIOCEPHALUS latus, rare human cestodes, [Yoshida & Ogata] 1994—ab
parvus, rare human cestodes, [Yoshida & Ogata] 1994—ab
DIBROMIN, 967
DIET: See also Nutrition; Reproduction; Vitamin; and under names of diseases
DIET and teeth, 1631—E
bone disorders induced by war-time dietary conditions, 1447—E
charts, for diabetes, [McCrudden] ★356
effect of, on mother's milk, [Courtney] 331—ab
effect of, on Vitamin B content of liver, [Osborne & others] 578—ab
favorite vegetarian foods, 2052—E
growth on high fat and carbohydrate diet, [Smith & Carey] 578—ab
influence of, on teeth and bones, [Toverud] 578—ab
measured, inadequacy of, as index of food metabolized, [Richardson] 156—ab
DIETL'S CRISIS, [de Sanctis] 505—ab
DIETRICH, appointment of, as ministerial director, 1562
DIGALEN-ROCHE (CLOETTA), 1937
DIGESTION, alkali reserve during, [Hollö & Weiss] 1155—ab
and leukocyte count, [Hainiss & Heller] 1308—ab, [Czubalski] 1152—ab
digestive leukocytosis and leukopenia in infants, [Ronchi & Sabatini] 1006—ab
electrolytes after food intake, [Wollheim] 1902—ab
idiopathic digestive insufficiency, [Mader] 2091—ab
peptic, [Kleinmann & Asada] 1740—ab
progress of food through the bowel, [Alvarez] 1887—ab
DIGESTIVE TRACT: See Gastro-Intestinal Tract
DIGITALIS by rectum, [Willius] 1397—ab
digitalization, 1067
evidence that digitalis influences contraction of heart of man, [Cohn & Stewart] 1721—ab
preparations, deterioration of, 912
standardization of, 911
DIPHTHERIA: See also Schick Test
DIPHTHERIA, anatoxin and toxin, [Ramon] 1004—ab
and atrophic rhinitis, [Kawano] 253—ab
antitoxin, 1067
antitoxin for infant, 228
antitoxin, freezing of, 912
antitoxin, intravenous injection of, [Mahood] 1080—ab
antitoxin, late serum sickness from, [Crooks] ★109
antitoxin, prophylactic use of, 1051—E
Antitoxin, Refined and Concentrated, 1047
antitoxin, sensitization to, 1383
antitoxin, use of rabbits for titration of, [Fraser & Wigham] ★1114
bacilli, use of rabbits for intracutaneous virulence tests of, [Fraser & Wigham] ★1114
bacilli, duration of vitality of, [Van Riemsdijk] 1576—ab
bacilli, streptodiphtheria, [Gaté & others] 1401—ab
bacilli, toxicity of, [Fukutaki] 2094—ab
bacilli, virulence of, [Gerbasi] 586—ab
carrier problem, relation of virulence to, [Lewis] 748—ab
carriers among school children, [Doull & Fales] 155—ab
control, problems in, [Jones] 147—C
deaths from, in chiropractor's family, [Ravenel] 568—C
diagnosis of, [Pergola] 1153—ab
gangrenous, unilateral, of pharynx, [Bourgeois & Aubin] 1737—ab
heart after, [Hecht] 1008—ab
immunity, distribution of diphtheria antibodies in passive and active, [Kassowitz] 1486—ab
immunity of infants to, 991
immunization, [Böhme & Riebold] 1233—ab, [Martin] 1898—ab
DIPHTHERIA immunization, active, results of, [Hooker] 1077—ab
immunization, spontaneous, [Lereboullet & Joannon] 1402—ab
laryngeal, fatal hemorrhage following tracheotomy for, [Schlaepfer] ★1581
measles associated with, [Reiche] 252—ab
paralysis, [Frontali] 250—ab. 813
paralysis after wound diphtheria, [Cavazzuti] 754—ab
reinfection in, [Reiche] 756—ab
Schick test, development of, [Schick] 1568—ab
Schick test, group reactions to, [White] 497—ab
Schick test in adults, [Destéfano & others] 167—ab
Schick test in children with adenoids, [Trauna] 341—ab
sex predisposition in, [Günther] 1827—ab
skin diphtheria in infants, [Reinhardt] 2093—ab
survey, [Godfrey] 1064—C
toxin-antitoxin, 228
toxin-antitoxin, effect of freezing on, [Kirkbride & Dow] ★1678, [Anderson & Leonard] ★1679
toxin-antitoxin, effect of low temperatures on, [White & Robinson] ★1675
toxin-antitoxin, frozen, 552—E
toxin-antitoxin, frozen, reactions of, [Kelley] 567—C, [McCoy & others] 567—C
toxin-antitoxin immunization against, [Dold] 1740—ab
Toxin-Antitoxin Mixture, 1047
toxin-antitoxin mixture, new, [Zingher] 748—ab
toxin-antitoxin mixture, serum sickness after, [Steele] ★1262
toxin-antitoxin mixtures, flocculation in, [Ramon] 502—ab
Toxin for Schick Test and Control,' 1047
toxoid as immunizing agent, [Glenny & Hopkins] 161—ab
DIPLEGIA, cerebral, pathogenesis of, [Collier] 65—ab, 1895—ab
DIPLOMAS, fraudulent: See under Licensure
DIPLOPIA, spasmodic, [Hyslop] ★1171
DIRECTORY, medical, publication of, in Mexico, 1134
of charities, 479
DISABILITY, temporary, length not be forecast, 654—MI
"loss of bodily function," 1720—MI
total, notwithstanding some earning power, 1386—MI
DISEASE: See also Infectious Diseases
DISEASE, chiropractic, "disease" and "diagnosis," 744—MI
disease, a luxury, 1798
notifiable, new list of, in France, 644
"DISFIGUREMENT" defined—when compensation is allowed, 1222—MI
DIURESIS, [Lützner & others] 757—ab
and hypertonic solutions, [Becher] 1903—ab
and liver, [Adler] 72—ab
and uric acid, [Ambard & Wolf] 1653—ab
cardiac and endocrine factors in, [Groedel & Hubert] 1487—ab
diuretic effect of crisis urine, [Carnot & Rathery] 1654—ab
extrarenal factors in, [Marr] 169—ab, [Weltmann & Schlüper] 170—ab
influence of, on sugar excretion, [Conway] 661—ab
Kauffmann's circulation test, [Heilbronner] 1905—ab
unilateral, [Fullerton] 1001—ab
urea diuresis, [Becker] 1660—ab
DIVORCE, shortcomings from hysteria not "cruel treatment," 233—MI
DIZZINESS: See Vertigo
DOCTOR, title of, 1705
DRAINAGE: See also Gallbladder drainage
DRAINAGE in surgery, [Hantcher] 585—ab
dependent, of perivesical region, [Chute] 1731—ab
surgical, of peritoneum, [Payne] 235—ab
temporarily reinforced drainage tube, [Printy] ★1779
DREYER VACCINE in Tuberculosis: See under Tuberculosis
DROWSINESS, ocular causes of, [Kearney] 1227—ab
DRUGS, addiction to, [Sceleth & Kuh] ★679, [Wholey] 910—C
addiction, abandoned theories regarding, 1976—E
addiction in United States, 1974—E
addiction, survey of narcotic problem, [Simon] ★677
addiction, tetanus as complication in, [Doane] ★1105
addiction, use of drugs not "habitual intemperance"—divorce, 1638—MI
addicts in Europe, 561
application of, on tongue, [Urbantschitsch] 1089—ab
basal metabolism and, 393—E
chemotherapy and proprietary pharmaceuticals, [Cheinisse] 752—ab
electrolytic introduction of, [Strohl] 340—ab
in Peru, 312
DRUGS, intolerance, epinephrin relieves, [Raeder] 430—ab
new, inconsiderate use of, 222
new studies of some widely used drugs, 213—E
procurable only in drug stores, 225
therapeutic substances bill in England, 1560
DUCTLESS GLANDS: See Endocrines
DUCTUS ARTERIOSUS, patent, aneurysmal dilatation of pulmonary artery with, [Moench] ★1672
DUEL between Professors Broca and Cunéo, 1133
DUODENAL TUBE, examination with, [Winterstein] 1232—ab
gastroduodenal tube, [Bársony & Egan] 1999—ab
knotting of, [Boles] ★303, [Niles] ★967, [Ruckstein] 1139—C
modification for duodenal tips, [Hollander] ★1264
DUODENUM, arteriomesenteric occlusion of, [Melchior] 342—ab
congenital fixation of, [Niles] 1887—ab
contents, chemical reaction of, [McClure & others] 919—ab
contents, hydrogen-ion concentration of duodenal contents, [Labbé & others] 1822—ab
contents, quantitative collection of, [Davidson] ★714
deformity of first portion of, [Bársony & Szemö] 664—ab
megaduodenum, [Melchior] 1086—ab, [Duval] 1821—ab
obstruction, chronic duodenal ileus, [Griffith] 1645—ab
obstruction, effect of inorganic salts on toxemia of, [Haden & Orr] 1148—ab
obstruction of, congenital, diagnosis of, [Schroder] ★686
obstruction of gallstone origin, [Papin] 1004—ab
obstruction, partial, causes dyspepsia, [Nesbitt] 1995—ab
obstruction, sodium chlorid in intoxication of, [Dixon] ★1498
secretion, enzyme activity of, [Spencer] 921—ab
secretion of children, bile salts in, [Taylor & others] 575—ab
stasis, chronic [McKenty] 1478—ab
tuberculous obstruction of, [Person] 1810—ab
Ulcer: See Peptic Ulcer
DURA MATER, repair of defects by free fat and fascial transplants, [Halstead & Caylor] ★1337
endothelioma of, in foramen magnum region, [Rhein] 1475—ab
fat tissue for repair of, [Hünermann] 2092—ab
sheet mica in brain surgery, [Kane] 1714—C
DUST, tons of, 801
DWARFS, metabolism in, [Staehelin & Gigon] 1089—ab
DYSENTERY, amebic, Chaparro amargosa in, [Goldsmith & Greene] 334—ab
amebic, treatment of, [Sellards & Leiva] 1979—ab
bacillary, chronic, [Robinski] 1088—ab
bacillary, diagnosis of, [Knorr] 253—ab
bacillary, dysentery agglutination in children, [Widowitz] 1158—ab
bacillary, immunization of children against Flexner dysentery, [Wilkins & Wells] ★1599
bacillary, preventive vaccine therapy of, [Gauthier] 752—ab
bacillary, prognosis of, [Froemsdorf] 664—ab
bacillary, treatment of, [Tinnemeyer] 1659—ab
bacillary, vaccination by mouth against, [Antonovsky] 1402—ab
bacillus and pasteurization of milk, 1211
bacillus, Flexner's, agglutinated by tuberculosis blood serum, [Hull & Renkes] 333—ab
bacillus, Shiga's, excretion of phosphorus by, [Pozerski] 1481—ab
in Philippines, [Padua] 1731—ab
sequelae of, [Walko] 72—ab
DYSPEPSIAS, chronic, of women, [Walton] 422—ab
duodenal, [Léon-Meunier] 165—ab
fermentative dyspepsia, [Lampé] 1575—ab
partial duodenal obstruction causes, [Nesbitt] 1995—ab
DYSPHAGIA, epidemic intermittent, [Vampré] 2089—ab
DYSPNEA, cardiac, [Sonne] 508—ab
cardiac, opium in, [Wilson] 422—ab
cerebrospinal fluid in, [Meyer-Bisch] 664—ab
in nephritis and hypertension, [Kornfeld] 71—ab
in vagus compression test, [Recht] 2149—ab
significance of, in pulmonary disease, [Meakins] 1651—ab
DYSTROPHY, adiposogenital, [Klein & others] 342—ab
adiposogenital, adult equivalent of, [Abbott] 746—ab
adiposogenital, and cerebral obesity, [Raab] 1486—ab
adiposogenital, nonpituitary, basal metabolism in, [Labbé & others] 1481—ab
adiposogenital, roentgenology in, [Raab] 72—ab
familial muscular, [Mills & others] 497—ab

DEATHS

A

Aaser, P., 1620
Abbott, Harry V., 734
Abernathy, Henry J., 734
Abernethy, William Green, 488
Abrams, Albert, 226
Abramson, Max, 1710
Acker, James Wilson, 226
Adair, John Hunter, 321
Adams, Charles, 1637
Adkisson, John Anderson, 907
Afzelius, 220
Agler, Homer L., 1563
Alamilla y Requejo, E., 1132
Alcorn, Edward, 1283
Alderson, Miles H., 2136
Aldred, John A., 564
Aldrich, Fred Eugene, 1215
Alexander, John H., 1380
Alexander, John Marshall, 1799
Allan, James Glen, 488
Allen, Albert Ammernan, 1063
Allen, Alice Gilleaple, 1380
Allen, Lemuel Sledge, 226
Allen-de Luca, Lida Taylor, 907
Allgood, James Edward, 906
Allgood, William Barnett, 488
Allison, John Ray Geddis, 1215
Amerson, George Walter, 1563
Amerson, William Henry, 1800
Amon, Jesse Adolphus, 1982
Anderson, George S., 1137
Anderson, James Henry, 50
Anderson, Manton E., 1283
Andrews, Charles Sylvester, 648
Antony, 1875
Anthony, Bertha Van Houten, 143
Antunez, Damazo, 402
Aplin, Charles F., 1063
Appleby, Thomas Renshaw, 1982
Applewhite, Lee Davis, 488
Arango, Ramon, 1979
Ardouin, J., 642
Armstrong, Jay Latrell, 811
Arnold, Barnard, 1062
Asbury, Levi Marquis, 226
Ashley, H. W., 1380
Ashman, William Edward, 2067
Ashton, Fielding Lewis, 144
Atkinson, Joseph, 1214
Atwood, Harley L., 1282
Auble, Clarence Sears, 1062
Aubry, Wallace Joseph Charles, 563
Avery, Hastings D., 1215

B

Bachman, Edsil W., 2067
Bacon, Frederick, 408
Bacot, Peter Brockington, 1711
Badaloni, G., 901
Bainbridge, Empson Haines, 563
Bair, George Elmer, 647
Baird, Alexander Barnett, 144
Baird, James Bozeman, 2136
Baird, William C., 2067
Baker, Elvin Franklin, 1880
Baker, Perry M., 226
Balcom, Parker Nathaniel, 2136
Baldwin, Beecher B., 1380
Balthrop, John Calhoun, 226
Bancroft, Charles Parker, 50
Bancroft, Edward, 1460
Bandeller, B., 1979
Bannerman, W. B., 983
Barker, Edgar E., 734
Barnes, Hugh Dyer, 1214
Barnes, Robert Harry, 1563
Barr, James Metheny, 226
Barraquer, José A., 1703
Barrett, Martin Clement, 2066
Barritt, W. Marion, 734
Barron, Clarendon W., 1460
Barth, William Edward, 1284
Basavilbaso, F., 901
Batcheller, James M., 1214
Baird, Andrew Tazewell, 1880
Bear, Alexander, 1380
Beard, Thomas Edward, 144
Beasley, Crawford Douglass, 1214
Berwick, Thomas Addison, 1711
Bell, Francis J., 1620
Benners, James Wemyss, 811
Bennett, Howard S., 988
Bennett, James C., 488
Bennett, Lafayette, 1880
Benton, William E., 1880
Berens, Thomas Passmore, 143
Bernd, Leo Heller, 226
Bernstein, Henry Alexander, 907
Berry, Joseph Thomas Bogan, 1283
Berry, William Clark, 143
Berryhill, Thomas A., 1982
Bertin-Sans, 1875
Bettis, Eli J., 144
de Beurmann, L., 642-986
Beyea, Henry Dorrance, 487
Biddle, Jonathan C., 1062
Bigelow, Frederick Nolton, 906
Biggs, Dennis Ellmore, 906
Biggs, Hermann Michael, 153
Bigham, Orville A., 1460
Billmeyer, George McClellan, 1800
Binckley, Albert Walter, 144
Bingham, Taylor J., 2136
Binnendijk, J., 402
Black, Albert R., 321
Black, Hardy C., 811
Black, Travis Raybourne, 2136
Blank, Charles F., 226
Blankenhorn, Henry, 648
Bleyle, Herman Conrad, 906
Bloch, Herbert Isaac, 1062
Blumauer, Frances Murray, 144
Boal, Varro M., 811
Boardman, William Sidney, 1710
Bogert, Edward S., Jr., 1379
Bohannan, Charles Lyman, 1283
Boldt, Henry Martin, 564
Bolotin, Jacob W., 1213
Bond, L. Lafayette, 2067
Bond, W. A., 1132
Bonner, Horace, 1563
Boone, Uriel S., 1563
Borthwick, Thomas, 1792
Boudreau, William Ralph, 1380
Bounds, Edward Henry, 1379
Bourn, Ernest L., 408
Bowen, James K. P., 1063
Bowles, Thomas J., 1563
Boyd, Wellington H., 988
Boylan, William Franklin, 321
Boyle, George Arthur, 488
Bradford, David S., 734
Bradley, William O'Reilly, 647
Brandenburg, 1620
Brannock, Benjamin B., 988
Brase, Ferdinand, 734
Brash, George Henry, 988
Brayton, Sarah H., 1215
Breeden, Samuel G., 1880
Breneman, Park Potts, 1214
Brereton, W. Westropp, 901
Brewer, Charles P., 1563
Brewer, Thomas G., 988
Brewster, Nathaniel, 647
Brice, John C. S., 408
Brisco, Clarence Alfred, 1380
Britto, Baptista, 1372
Broderick, John Joseph, 1283
Brooks, Andrew J., 1284
Brooks, Macy, 2066
Brown, Curtis, 1283
Brown, Herman Erastus, 1137
Brown, Joseph Erastus, 226
Brown, Ralph D. P., 1380
Brown, Walter John, 1711
Brown, William Durbin, 564
Brown, William Lewis, 1461
Browne, J. Walton, 402
Brubaker, Frank Barton, 564
Bruce, Charles Eli, 1460
Bruggen, van A. C., 642
Brusie, Donald Wilmott, 1461
Bryan, Charles Samuel, 408
Bryan, Henry Hugh, 648
Bryant, Paschal E., 226
Bryant, William Cullen, 1627
Buchanan, Marion Washington, 408
Buchanan, Walter J., 1372
Buck, Aug.stus Walker, 1460
Buck, Harmon A., 1137
Buckley, Daniel, 50
Budge, William H., 226
Bunker, David Wellington, 1563
Burchard, E. Adelbert, 1380
Burk, Charles M., 144
Burke, George Herbert, 988
Burke, John H., 1380
Burke, Richard Frederick, 226
Burnett, Nagle, 402
Burnham, Ernest Lindwood, 1880
Burr, Chauncey Rea, 50
Burres, Walton Todd, 143
Burt, Augustus Moody, 734
Burt, John Crombie, 734
Burton, C. M., 1380
Butler, Edward Allison, 226
Butler, Fletcher Asbury, 1283
Butterfield, Forrest Russell, 50
Byrne, Thomas Joseph, 1063

C

Caldwell, Francis C., 1063
Callan, John, 50
Calnane, John Andrew, 1880
Campbell, John A., 2136
Campbell, Roy O., 1284
Campbell, William H. H., 1982
Campbell, William Rutherford, 1380
Cannon, William H., 1982
Capell, Western L., 564
Capp, John A., 2136
Caramanda, G., 804
Carpenter, Charles Darwin, 2136
Carpenter, Frank S., 1380
Carr, E. Arthur, 647
Carr, Matthew S., 1380
Carrier, Frederick H., 1137
Carrow, Joseph, 144
Carter, George William, 1711
Case, George G., 2067
Cason, Davis Elmore, 1880
Cassidy, Patrick, 906
Castleman, Philip, 1213
Castro, Maximo, 402
Catanjal, y Garcia, Andres, 321
Caton, Charles Wesley, 1283
Cavana, Martin, 320
Cearnel, Archie E., 1563
Chamberlin, Marcus Philander, 408
Chaney, Mitchell L., 1880
Chapman, Charles McVey, 564
Chapman, George L., 488
Chapman, John Joseph, 1563
Chapman, Joseph Beach, 1214
Chapman, Oscar M., 1284
Chapman, Ozias S., 734
Chase, Milton, 1880
Chauvin, Hubert Emil 988
Cheatham, Samuel R., 1982
Cheever, John Howard, 1563
Childs, Benjamin Neely, 1063
China, Archie, 408
Chittick, Andrew J., 144
Chronquest, Alfred Peter, 226
Church, Gilbert Leighton, 1379
Cisin, Morris, 1461
Cissell, Joseph K., 2067
Clark, Asa Elizabeth, 1132
Clark, Miles Harison, 811
Clark, Robert Washington, 1214
Clark, Samuel Milton, 811
Clarke, Augustus Tupper, 1380
Clarke, Charles Kirk, 488
Clarke, William Bradley, 2136
Clarke, William C., 2067
Clemens, Willis Patterson, 1982
Clemons, Robert Nelson, 1628
Clendenen, George W., 1215
Cline, Raoul Rene Daniel, 1982
Clinghman, John J., 907
Coakley, John B., 2136
Coates, Frederick Preston, 1380
Coburn, John Beaton, 988
Cockrill, Bruce T., 408
Coffman, Gilbert Lee, 1711
Cohen, Louis Lippman, 906
Cole, George Henry Philip, 1214
Coleman, John M., 1628
Colt, Emily Sibley, 321
Colville, R. W., 1461
Comey, Perley Pierce, 1062
Comings, Arthur F., 1563
Condon, Eva G., 321
Conner, Elspeth M., 1283
Cook, James Wilson, 50
Cook, Katherine M., 1711
Cooke, T. Bates, 564
Cooper, James Monroe, 321
Copeland, Oscar, 563
Corbett, James Sherman, 1982
Corey, Dunnleigh, 1710
Cormack, Allen W., 1380
Cornell, William Paterson, 906
Corsant, James Calvan, 226
Cortes, Carlos, 1372
Cory, Charles Theodore, 988
Costamagna, G., 1877
Cotes, Samuel, 804
Cottel, Willis I., 1460
Cotton, Henry Carville, 488
Cox, Joseph Abram, 1284
Cragg, F. W., 1792
Crain, Ambrose Burdett, 2136
Crampton, Orson Lucius, 2067
Cranmer, Harry J., 1711
Craven, Joseph John, 988
Crawley, Zebulon Thomas, 50
Creel, Thomas J., 50
Crespo, F. E., 1057
Creveling, Hanley Clay, 1283
Crommett, Herbert B., 648
Crook, Harrison, 1137
Cross, Albion Arthur, 1380
Crowe, Thomas M., 1063
Cruickshanks, Archibald, 2067
Crumrine, Charles G., 407
Cullen, Francis Edward, 1214
Culley, Albert B., 1284
Cullom, William C., 2136
Cunningham, George, 733
Cunningham, William Wallace, 907
Curry, Edward M., 1711
Cyphers, Edward Oglethorpe, 1982

D

Dabney, Thomas Smith, 50
Daggette, Alvin St. Clair, 1880
Daily, George W., 1284
Dalton, William Bluford, 1062
Daly, Bernard Thomas, 1062
Dalziel, Kennedy, 901
Dann, Richard H. V., 1062
Darden, George Thomas, 320
Darr, Royal Walter, 488
Davidson, Charles Fitzsimmons, 1461
Davidson, William Robert, 488
Davies, Frederick Ambrose, 488
Davies, Thomas Bernard, 648
Davis, Arthur Fletcher, 648
Davis, Charles Allen, 1982
Davis, Edward J., 2067
Davis, George Washington, 1982
Davis, S. Austin, 1379
Davis, Thomas V., 408
Davis, Walter, 2067
Davis, William H., 144
Dawson, Albert, 1063
Day, Charles Alan, 1283
Dean, Joseph Wilson, 320
Deevy, Joseph Paul, 1063
De Giacomo, A., 138
De Gouvêa, Hilario, 220
Demetriads, G., 1621
Deny, G., 43-47
Dennis, Earl Bentley, 1460
Derr, Joseph L., 564
D'Evant, T., 1377
DeVilbiss, Georgiana, 2067
Devlin, Thomas Patterson, 320
Dewar, Bennett White, 144
Dewey, George W., 1800
Deyl, Jan, 983-1377
Dial, John Joseph, 1379
Dice, Laura J., 1283
Dickey, Finis Jackson, 734
Dickinson, Elmer John, 1379
Dickinson, Julius Charles, 1214
Dills, Malcolm, 1283
Dirks, Charles B., 487
Dishrow, Frank Irving, 1283
Dissinger, Hiram C., 648
Dixon, Archibald, 2136
Dixon, Cyrus B., 811
Dodge, George Francis, 1711
Doles, Julian Thomas, 1137
Domínguez, Julián Sierra Y., 1979
Donahoe, Michael Joseph, 988
Donnell, Robert E., 226
Dooling, James Vincent, 2067
Doron, John George, 906
Douglass, John Birch, 1711
Downer, Mary Alice, 564
Downs, Lloyd S., 1880
Drake, Josiah T., 811
Drake, William D., 1880
Dresel, Gustav, 321
Drumheller, Floyd Douglas, 1982
Drury, M. Francis, 321
Duffey, Hugh Clarence, 1982
Duncan, Curtis Norton, 1460
Duncan, William, 1628
Dunfee, Joseph W., 1137
Dunsmore, Albert Frank, 1460
Duplay, Simon, 558-561
Dupuy, E., 901
Durham, John Lindsey, 488
Dutcher, John E., 906
Dutro, Edgar O., 1215

E

Eakin, Allen Chancellor, 906
Easterday, George Spalatin, 1214
Eblen, William H., 1214
Eddy, Robert Condit, 2067
Edelen, Joseph Eliot, 988
Edmonds, Andrew J., 1380
Edwards, James T., 1137
Edwards, Thomas R., 1982
Eggen, Olaf K., 1283
Eikenberry, Aaron A., 1215
Ela, Walter, 564
Elder, Brice Howard, 2136
Ellero, L., 558
Ellingwood, Charles Victor, 1137
Ellis, Arthur C., 811
Ellis, George Jesse, 1711
Ellis, Katharyn W., 1063
Ellis, Mumford W., 988
Emmons, Davis R., 144
Emrys-Roberts, Edward, 558
Erwin, Frank J., 1215
Essington, Uriah Kinder, 1799
Etter, Harry Havelock, 733
Etter, Jacob Riley, 2067
Evans, David Richard, 1214
Evans, William D., 321
Everitt, Martha Smyth, 1563
Ewald, A., 901
Exley, Maud Conyers, 1563

F

Fahrney, Bert Emory, 648
Farmer, Charles, 2136
Farmer, George Wilmot, 1982
Farmer, S. B., 1379
Faulk, Henry Walker, 988
Faulkner, George Washington, 1379
Fauntleroy, Claybrook, 734

Feare, Walter Keith, 1380
Feltwell, A. Lincoln, 144
Ferguson, Bertram James, 50
Ferguson, Luther Franklin, 1711
Ferguson, William, 564
Ferguson, William Milligan, 320
Ferreira, Antonio da Silva, 1703
Ferreira, L., 1132
Fessler, Elmer, 1380
Field, Archelaus G., 2066
Finch, Edward Willis, 1380
Fincke, Harry Stark, 488
Finn, William Dominick, 2136
Finnessy, James Henry, 1283
Finch, Gustav Grant, 1711
Fisher, Arthur L., 1284
Fisher, Chester Irving, 1627
Fisher, Erastus Scott, 488
Fisher, Frederick Alfred, 1627
Fisher, Marvin Floyd, 1379
Fisher, Robert W., 402
Fittro, Edmund Brenton, 1062
Fitzgerald, Edward, 2066
Fitzgerald, John F., 647
Fitzsimmons, James Cleland, 1379
Flack, John Bradford, 1380
Fleming, John R., 1214
Flowers, Jarrot C., 144
Flynn, Timothy John, 488
Foland, John Philip, 1380
Foley, John Christopher, 408
Follett, Earl Christie, 143
Follweiler, David W. W., 488
Foote, Mary E. Bond, 1062
Foreman, James Milton, 1063
Foskett, Wilson A., 1563
Foss, Carl Elmer, 1062
Foss, George Herbert, 1062
Foster, Lysander P., 1380
Fowler, Alfred Lucius, 906
Fox, Jay E., 1284
Fox, Richard H., 1792
Fralick, George W., 1982
Frames, William Wayland, 143
Francine, Albert Philip, 1137
Francis, Thomas Benton, 1800
Frankel, Edward, 50
Frankel, Leopold, 1215
Frederick, Mary D., 1711
French, Winslow Burrell, 1799
Friedinger, K., 1057
Frink, Oscar George, 2067
Fryer, John Langley, 488
Fuller, Duncan MacTavish, 1062
Fyle, Frederick Edward, 1627

G

Gale, Frank Jasper, 733
Gallagher, Morton, 988
Gallison, James Murry, 2136
Galsgie, Edward Carl, 648
Gamble, Joseph Bryant, 1380
Gandy, James Luther, 2067
Garbutt, Frank, 1800
Gardner, Jairus B., 321
Gardner, J. Almus, 321
Gardner, Levi W., 564
Gardner, Samuel Howell, 1283
Gariel, C. M., 1372-1375
Garlick, Samuel Middleton, 1628
Garlock, Perlin Elijah, 1627
Gatewood, James Duncan, 1460
Gatewood, Wesley Emmet, 563
Gehrung, Eugene Charles, 1460
Gemmill, Henry Clay, 488
Gengelbach, Ernest E., 988
Genn, Abraham, 1062
Georgi, Sophia E., 564
Gibbons, Richard Henry Conway, 1379
Gibbs, John A. M., 1880
Gibson, Charles W., 1880
Gibson, Ira James, 1460
Gifford, Herman Lincoln, 648
Gifford, William Utley, 320
Gilchrist, Colin, 1283
Gillespy, John Sharp, 1880
Gillette, Leon Michael, 1563
Gilliam, L. Hugh, 907
Gist, D. R., 320
Gleaves, William Louis, 1461
Glenn, Eugene Byron, 1380
Glover, Samuel Gilman, 1284
Gnichtel, Albert Lawrence, 1215
Godfrey, Byron Benjamin, 1800
Goessling, Mabelle Van Horn, 564
Goldsborough, Martin W., 321
Golseth, Gustave, 1461
Good, Harmon, 1379
Goodale, Walter Temple, 648
Goodwin, John B., 1137
Gordon, Baltzer L., 1284
Gordon, William St. Clair, 1710
Gotham, Charles Lewis, 1711
Gotwald, David King, 408
Goudy, Rollin Andrew, 1711
Gould, Otis, 1880
Gourlay, Henry B., 1214
Graefe, William, 143
Graf, Edmund Lewis, 988
Graham, Charles Robert, 1979
Graham, Oliver P., 50
Gram, Franklin Charles, 906
Granay, Thomas Logan, 1062
Gratiot, Charles C., 1880
Gray, Daniel Arthur, 1982
Gray, Henry, 1213
Graybill, Leon A., 1062
Green, James E., 1628
Green, Samuel M., 1137
Greene, Alfred Buford, 1284
Greene, Eva Keith, 1380
Greene, Harry Paul, 2067
Gribble, Russell Thornton, 1062
Griffith, Thomas Jefferson, 408
Grim, Frank Seymour, 1982
Grossman, Edward Lorenzo, 50
Grover, Fred, 1379
Grün, H., 901
Gruver, Samuel James, 906
Guggenheim, Max, 1214
Guillet, Noel Eusebe, 408
Guillon, Paul, 1372, 1562
Gunn, Janet, 1213
Gurnee, George Washington, 1379
Guthrie, Herbert S., 1214
Gwyer, Frederick, 320

H

Haas, Edwin S., 1283
Hackley, Alice M., 1460
Hackworth, C. L., 2067
Hahne, Henry Anthony, 408
Haines, Eleanor, 1711
Haines, Ignatius, 408
Hains, Franklin Waters, 320
Hale, George Weeks, 1627
Haley, Peter Arthur, 1214
Hall, John Evans, 1062
Hall, Nelson Read, 1137
Hall, Willis M., 1880
Halsey, Henry Allen, 2136
Hamburger, H. J., 402
Hamilton, John W., 734
Hamilton, Samuel, Jr., 1062
Hammond, Jerry Chadwick, 906
Hammond, William Randolph, 320
Hancock, James Francis, 144
Hanes, William W., 1214
Hanna, Alexander B., 1982
Hansen, George Henry, 648
Hansler, John Emerson, 1880
Hardin, James Otis, 1627
Harlan, Warren E., 564
Harlow, William Page, 1710
Harris, Charles Church, 408
Harris, Fred Hopkins, 50
Harris, John Wesley, 1880
Harris, Theodore C., 1982
Harrison, Alfred J., 1132
Harrison, Roscoe C., 1215
Harrison, Samuel Ingelby, 488
Harrison, William H., 1711
Harrod, James, 1380
Hart, Harlan Harvey, 1283
Hartford, William Preston, 564
Hartinger, Daniel S., 1284
Hartman, William Weaver, 1563
Harvey, John B., 2066
Hasbrouck, Cornelius Van Dyke, 1137
Hassenplug, Galen K., 488
Hatch, Frederick W., 1062
Hatfield, Raymond Lafevre, 2067
Hatton, Edward Alexander, 1380
Haugan, Otto M., 1982
Haworth, Elwood R., 1627
Hawthorne, Lilla, 50
Hayden, Clara May, 564
Haynes, Lorenzo D., 1880
Hays, Wilfred Bertram, 1062
Hayward, Henderson, 1563
Hazelton, Charles Norman, 648
Hazlet, Edwin A., 1982
Hechelman, Herman W., 733
Helder, James E., 988
Heintz, Jean Pierre Edmond, 1137
Heinze, O., 901
Helm, J. K. A., 1372
Helminak, Joseph John, 1628
Henderson, Alexander Taylor, 1628
Henderson, Generous Leander, 1063
Henderson, William C., 1460
Hendon, A. L., 1880
Heudren, George Marion, 1563
Henington, Frank W., 226
Henna, Joseph Julio, 647
Hennessey, Edwin Zac, 1460
Henry, Samuel L., 321
Hensen, V., 1621
Hensley, Jasper Wayne, 1711
Hering, Joseph Trumbo, 1284
Herron, Charles R., 1380
Hesler, George F., 144
Hewett, Frederick G., 1283
Hewlett, Lon Lemuel, 1379
Hewson, Edmund Thomas, 564
Hibbe, Charles Harris, 144
Hickman, Zachariah, 226
Hicks, Susan Mary, 811
Higbee, Albert Enos, 1380
Higginbotham, Edward L., 1063
Higgins, Daniel Witter, 907
Higgs, Frederick W., 1620
Highley, Edward S., 143
Hight, John P., 564
Hildreth, Charles Lewis, 648
Hildrup, Josephine P. Wheeler, 906
Hilferty, Edward Francis, 408
Hillier, Solomon Cartwright, 1137
Hinsdale, Albert Euclid, 1799
Hodge, Duke, 408
Hodkinson, William Austin, 1062
Hoffmann, Jacob Ludvig, 1284
Hofheimer, Justinian Aiman, 906
Hogg, Cassius Clay, 1214
Hohman, George, 906
Holch, H. N., 1132
Holcomb, Irl Edward, 1461
Holcomb, Thomas J., 144
Holcombe, Howard Morton, 1062
Hollingshead, Enoch, 906
Holmes, Bayard Taylor, 1213
Holmes, Florus Eugene, 564
Holmes, John Funnell, 1627
Holmes, Percy Kendall, 320
Holmes, Thomas G., 1563
Holmes, William C., 1215
Holt, Luther Emmett, 320
Holton, J. O., 1380
Holub, E., 983
Honeij, James Albert, 563
Hood, Donald, 1277
Hooper, John Orville, 488
Horine, William Henry, 1380
Houser, Jacob H., 1063
Houser, Solon K., 1563
Howard, Clarence C., 733
Howard, John J., 734
Howerton, David L., 1800
Howle, Thomas Roland, 144
Huber, John Bessner, 811
Hudgin, John Hagen, 144
Hughes, Harry Adams, Jr., 906
Hughes, Lot H., 1711
Hughes, William Blakemore, 2066
Hull, George Malcolm, 408
Humphreys, John Edgar, 1711
Hun, Henry, 1062
Hunt, Bader S., 1283
Hunt, John, 407
Hunt, John M., 488
Hunt, John Simeon, 1063
Hunter, Sylvester Green, 648
Husted, Joseph Marshall, 1711
Hutchinson, Alexander Franklin, 811
Hutton, John G., 1215
Hyatt, Lorin Draper, 408
Hyatt, William W., 562
Hyde, William John, 563
Hyndman, Peter, 564
Hypes, Benjamin Murray, 487

I

Insko, Mark, 811
Irving, Henry Washington, 1628
Irwin, John H., 1062
Irwin, William B., 564
Isherwood, Hortense Lowry, 1137
Ivy, Thomas G., 408

J

Jackson, James M., 1283
Jackson, Roscoe Neely, 320
Jacobs, Charles, 1621-1797
Jacobs, John M., 906
Jacobs, Leon, 1799
James, Addison Coffea, 321
Jameson, Henry, 811
Jamison, J. C., 1711
Jenson, Charles, 1880
Johnson, Robert Irwin, 988
Johnson, John Hickman, 144
Johnston, George David, 1379
Jones, Gay Amasa, 1215
Jones, George Orville, 1284
Jones, Gilbert Norris, 563
Jones, Henry H., 2136
Jones, Horace E., 1460
Jones, Lyle E., 1380
Jones, Richard, 1792
Jones, William Watson, 1215
Jordan, Edward Henry, 1062
Joy, Percy Clark, 906
Judson, George W., 1800

K

Kaczander, G., 1372
Kakeles, Moses Seligman, 320
Kalb, Charles S., 1982
Kambourian, Hovhannes Artyn, 734
Kane, Joseph James, 144
Karney, Roy Foster, 408
Katherman, Frank Clark, 564
Kaull, Lee Perry, 144
Kelley, Edward James, 1215
Kelley, James Louis, 144
Kelley, Warren, 1137
Kennedy, Isaac S., 1461
Kent, Maude, 1800
Keplinger, Edward, 1214
Kerr, Irvine J., 1215
Keyes, Edward Lawrence, 487
Kiddoo, Samuel Ralston, 811
Kieffer, Edward John, 1800
Kilmer, S. Andral, 408
Kilpatrick, Harry Gray, 1137
Kincaid, Douglas Howard, 50
King, Albert Edgar, 811
King, Charles Dilworth, 2067
King, Harvey Thomas, 1063
Kingston, Augustine Thomas, 488
Kinnaman, Horace A., 320
Kinyon, Henry Eugene, 564
Kirk, Edward, 1880
Kirk, James A., 907
Kirk, Joseph Raymond, 1461
Kirkland, W. Clifford, 811
Klapp, William Henry, 488
Kleen, E., 220
Klein, Arno, 1880
Kline, Andrew K., 1711
Kline, Roscoe Texter, 408
Klotz, Bernrd John, 811
Klynens, 1277
Knapp, Charles, 1380
Knight, Charles Asher, 408
Knop, Ladislav, 907
Knowles, James Harris, 1880
Knowles, Ralph Norvel, 907
Knox, John, 811
Kölner, H., 901
Kompert, Gustav, 907
Königstein, Leopold, 646
Korner, Christopher F., 144
Kramer, Homer Finley, 408
Krebs-Japy, 804
Krehbiel, Andrew J., 1215
Kresensky, Walter William A., 906

L

Lackie, James L., 558
LaFerte, Daniel, 1799
Laget, E., 1277
Laker, Lashbrook Bryceson, 734
Lal, Rai Bahadur Hira, 1372
Lambert, Harry Furniss, 1563
Lambling, Eugene, 1210-1277
Lancaster, Albert Chapman, 320
Lance, Ruth Mitchell, 1880
Landenberger, John, 1880
Landis, Amos J., 1284
Lane, Arthur Ernest, 1563
Lane, Charles M., 1711
Lane, James, 1563
Langlois, Joseph Augustin, 988
Langrill, John Alexander, 50
Langworthy, Simon Burton, 1460
Lansdown, Robert G., 1132
LaPlace, Ernest, 1710
La Rocque, J. Henri, 1379
Lauder, John W., 733
Laul, John Ernest, 1799
Lawrason, William Lavern, 50
Layne, Porter Campbell, 407
Leach, Edward Morton, 733
Leake, Henry Sabin, 1711
Leaman, Adam E., 144
Leaman, Henry, 144
Leap, Harry Leroy, 1710
Leavell, Hugh Nelson, 1563
Le Boutillier, William Guitton, 144
LeClar, Leo Cowling, 1137
Lee, A. M., 906
Lee, Bernard Richard, 1461
Lee, George Henderson, 1213
Lee, Joseph E., 226
Lee, Robert Henry, 320
Leech, Garrett David, 1982
Leedom, John Milton, 1137
Leeds, Charles, 144
Leftwich, Daniel Minard, 907
LeGwin, John Bunyan, 1711
Leighton, Charles Milton, 1283
Leiser, William, 1707
Leland, George Adams, 1137
Le Master, Robert R., 983
Leonard, David Oliver, 564
Leonard, Samuel Cecil, 733
Leone, R. E., 1621
Lermoyez, J., 220
Levine, Edgar Clarence, 1800
Lewis, Arthur G., 1880
Lewis, Byron, 1792
Lewis, Walter Clark, 144
Liebe, G., 983
Lightfoot, Jean Allen, 1711
Linder, Thomas Lawrence, 1711
Linossier, Georges, 138
Littell, Robert Moses, 1711
Little, William Brimblecom, 1627
Littlefield, John Ramsey, 1627
Lively, Mark Henry, 1380
Locke, James K., 1137
Lockwood, Eph, 1982
Loeb, Jacques, 563
Long, Frank A., 1982
Loomis, Albert Jerome, 1063
Loomis, Brace Wheelock, 488
Loughridge, Sherman, 563
Lowe, James Harris, 1062
Lowell, Freeman Lamphrey, 907
Lowenfeld, L., 558
Lowry, Andrew Clark, 988
Luck, Byron Bedford, 1460
Ludewig, William Henry, 2067
Lukasiewicz, W., 1621
Lumley, Edward D., 1982
Lund, Theodore Christian, 1283
Lupher, James Melville, 1380
Luschan, von Felix, 905
Luster, George W., 321
Lutz, Earnest J., 647
Lynch, William Mercer, 988
Lyon, Samuel Backus, 1799
Lyons, Edward Laurence, 647
Lyons, William Henry Aloysius, 1379

M

MacCaskill, John Alexander, 2136
MacDonald, John Andrew, 2136
MacDowel, Effingham C., 1132
MacEwen, William, 1132
MacKay, John S., 1620
MacLachlan, William Evarts, 1063
MacLellan, Charles, 1460
Madison, William B., 1137
Magee, Irvin L., 2067
Maggard, Irvin Johnson, 648
Mahon, Wilson H., 1628
Mahoney, John James, 811
Mahoney, Virginia, 1380
Mahood, Hugh Benjamin, 1711
Mallan, Thomas Francis, 1379
Malone, William F., 1214
Malotte, Karl Raymond, 50
Mandeville, John Drake, 1461
Mankin, Frank Dallas, 1711
Marberry, Flavius J., 2067
Marcil, Alfred, 814
Marcy, Henry Orlando, 226
Marden, Orison Swett, 1137
Maroni, Arrigo, 804
Marrow, Charles E., 1982
Marsolais, Avila R. L., 1982
Martin, Brayton A., 1215
Martin, Charles Marion, 1628
Martin, Henry Marcellus, Jr., 988
Martin, James E., 1380
Martin, James Everett, 988
Martin, Owen P., 648
Martz, George Jamison, 648
Matlock, Thomas, 1460
Matthews, Harvey Lee, 1380
Matthey, Henry E., 988
Mattice, Albert Francis, 226
Maurer, James Monroe, 1215
Maxer, Maria Blair, 1213
Maxwell, Charles James, 2136
Maynard, Henry C., 488
Mazzei, Francis A., 564
McAlpine, Lemuel A. Wilmot, 1214
McArthur, John Ferguson, 1283
McAuliffe, James, 1379
McCallum, Samuel, 811
McCampbell, William E., 563
McCaw, John, 1056
McClelland, Robert Edward, 1982
McClung, Park W., 988
McConaughy, Robert, 143
McCormick, Francis P., 2136
McCormick, Horace G., 1213
McCoy, John Cresap, 563
McCracken, Jesse F., 1380
McCreary, Henry, 320
McCrystie, John, 1215
McDonald, John A., 321
McDonald, Samuel A., 734
McDonald, Thomas Benton, 1461
McGeary, George Harvey, 648
McGee, James McMeekin, 408
McGilawee, John 1214
McGill, John A., 648
McGlean, James Averill, 1284
McGrew, William Mastin, 1461
McGuire, J. Frank, 2067
McKenna, Peter George, 733
McKennan, Moore Sheaffer Stockton, 564
McKenzie, George, 811
McKilop, Alexander, 648
McKinney, William G., 2067
McKown, Charles Lemon, 1283
McLaughlin, Frank W., 226
McLean, Malcolm, 407
McLennan, Donald Archibald, 226
McLennan, Henry Etherington, 1563
McMillen, Samuel, 1563
McMurdy, William Smith, 1880
McMurtry, Lewis Samuel, 487
McNally, James, 1379
McNatt, W. J., 1380
McNeal, Harry, 1214
McNutt, William Fletcher, 647
McQuade, Harry D., 488
McWilliams, James P., 1380
Meek, Allen W., 988
Meeks, Harold Albert, 226
Melvin, Henry B., 1215
Menefee, Peter M., 2136
Menuet, Francois, 1312-1562
Merchant, William Fewell, 988
Merenna, Giovanni, 2136
Merrill, Liburn, 1880
Merrill, Ralph Teancum, 143
Metts, Fred Arlington, 226
Michael, Adolph, 907
Middlekamp, Marion S., 1215
Miesse, Leon, 321
Miles, Frederick Thomas, 1799
Millie, Germano, 988
Miller, Adam Ewing, 226
Miller, Albert Noah, 2067
Miller, Andrew Edward, 733
Miller, Cynthia A., 2067
Miller, Franklin A., 564
Miller, Henrietta Caroline Puthoff, 988
Miller, Henry J., 1284
Miller, Paulus Fitz James, 734
Miller, William Aaron, 1460
Millick, John W., 1628
Millis, Eugene D., 408
Mills, Charles H., 1563
Mills, R. Walter, 733
Mitchell, James C., 50
Moffett, William Nelson, 564
Moncayo, Jesus, 1373
Monie, Thomas, 1284
Monk, Robert William, 1213
Montero, E., 1372
Montgomery, John Edward, 50
Mooney, John James, 1982
Moore, David B., 1137
Moore, Fitz Randolph, 1283
Moore, John A., 1215
Moore, Robert M., 564
Mooring, Christopher M., 1137
Moorman, Alban, 811
Morehouse, Cecil Goddard, 1137
Morgan, Campbell William, 1057
Morgan, John D., 1461
Morgan, Thomas W., 1800
Morrical, Frank Helton, 321
Morris, Malcolm, 727
Morris, Michael Augustine, 907
Morrison, George A., 1214
Morrow, Calvin Jenkins, 733
Morrow, Samuel Rosebaugh, 811
Moseley, Edward Julian, Sr., 1627
Mosteller, William H., 1062
Mowery, Henry A., 811
Moy, Jin Fuey, 1711
Mrazek, Alois, 224
Mueller, Carl Ludwig, 906
Mullen, J. W., 1056
Mulloy, Thomas B., 2067
Muncie, Edward H., 2067
Munsey, Samuel E., 1711
Murch, Albert J., 408
Murphy, Charles Augustus, 321
Murphy, James B., 2067
Murphy, Thomas Burke, 320
Murray, John Lovell, 1880
Musser, Charles Sumner, 734

N

Nairn, William, 1982
Nape, Frank Le Roy, 1284
Napier, James Lane, 1880
Nelson, John Alexander, 2067
Nelson, John C., 1214
Nesmith, Francis Marion, 407
Nevling, Ferdinand S., 648
Newbolt, George T., 1132
Newman, David, 1979
Nickell, H. Volney, 1283
Nielson, Christen S., 50
Nolan, John, 1711
Normandin, Louis Zephirin, 647
Norton, George M., 988
Noxon, George Henry, 144

O

Ochoa, José T., 1979
O'Connell, Joseph Henry, 1880
Ogden, Charles Ludlow, 488
Oglesby, John Thomas, Jr., 988
Oliver, G. H., 1792
Oliver, George H., 2067
Olmstead, David S., 1800
O'Neill, Thomas Joseph, 1799
Onontiyoh, Peter, 488
O'Reilly, Thomas William, 1214
Orendorff, Otis, 733
Orton, John G., 1460
Osterhout, Edgar Randolph, 1800
O'Sullivan, Alexander C., 983
O'Sullivan, John Joseph, 1063
Owen, Orville M., 1284
Owens, Frederick Francis, 320
Oyler, William H., 1880

P

Pace, Jerome Grant, 1137
Palmer, Benjamin H., 988
Palmer, Charles A., 144
Palmer, Ramon Clark, 811
Palmer, Harold Lucian, 1627
Paltauf, Richard, 1703
Pancake, Arthur, 488
Parent, Henry, 1875
Parker, William, 143
Parrott, Archie Rosco, 1982
Parry, Ivan Arthur, 1214
Parvis, W. Arlett, 2067
Paschal, George Dennis, 1711
Pasha, Rechard, 1132
Paterson, Charles Blome, 1628
Patterson, R. D., 1380
Patton, William Brooks, 1137
Paxton, Cornelius P., 734
Peckham, Frank Edwin, 1460
Pellissier, 402
Pemberton, Calvin W., 1137
Pepler, William Herbert, 2136
Pérez Minguez, Ricardo, 1620
Perrins, William Arthur, 734
Perry, George Lewis, 564
Peter, Robert, 648
Pettijohn, Abra C., 1379
Pettijohn, Otto B., 408
Pettit, Robert Walter, 408
Phillips, James Jones, 1380
Phillips, Thomas Graham, 50
Phillips, William Henry, 1214
Pick, Arnold, 1621
Plecker, James Henry, 988
Plumer, Edward Marwick, 320
Plunkett, Benjamin Jesse, 488
Poindexter, J. K. P., 564
Pollack, George W., 138
Pollard, William Marion, 1880
Pollock, James K., 488
Pollosson, A., 558
Poore, Alvin Brainard, 1283
Postell, Laurens Toomes, 1283
Postlewait, John A., 226
Powel, Milton, 647
Powell, Robert Llewellyn, 2067
Powell, William Dunn, 320
Powers, Vance C., 50
Powley, Joseph E., 2067
Pratt, John Overton, 564
Prendergast, John P., 1063
Prewitt, George Elgin, 488
Price, Henry R., 1460
Price, William D., 1628
Prickett, Elmer Delaney, 1062
Priest, Howard, 563
Priestley, Charles Wilfred, 408
Primm, John Newton, 1214
Proctor, John Peebles, 1460
Proctor, Thomas Walter, 811
Proffitt, James H., 408
Prudden, Theophil Mitchell, 1379
Prunty, Frank J., 1711
Pryor, Rowan Barclay, 906
Pulsipher, Hyman H., 564
Purdon, James, 321
Purser, John Lenwood, 1063

Q

Quillian, Harvell P., 1063
Quinn, Edward A., 1880
Quinn, James Almarin, 226

R

Rabenstein, Hans, 1628
Radcliff, Sue, 1461
Rader, Samuel W., 564
Ragsdale, Archer C., 1137
Ragsdale, Edward W., 320
Rambo, Harry Marion, 2067
Ramsey, William Stewart, 811
Randall, Hiram L., 1628
Randolph, Tucker Lucas, 1137
Rankin, Theodore W., 647
Ratliff, John Marvin, 1214
Rauterberg, Lewis E., 1340
Rawers, Henry George, 1461
Reading, George Evans, 1215
Reall, G., 402
Redman, Joseph R., 1215
Redpath, Nathaniel J., 1627
Redus, William Dickson, 1628
Reece, Richard J., 1792
Reed, Elgar, 734
Reemtsma, Rudolph H., 1880
Reese, Joseph, 1800
Reeves, Allen J., 1711
Reid, Archibald D., 558
Reidharr, 804
Reineking, Herman, 407
Reinhart, James C., 1380
Renaker, John R., 1982
Requa, Mary Augusta, 907
Rethi, L., 983-1281
Reusch, Theodore Frederick, 811
Reynolds, John M., 1982
Reynolds, Samuel M. C., 1379
Rhem, Joseph Franklin, 1284
Rhodes, John M., 1214
Richards, Camillus E., 1284
Richards, Charles Egbert, 1880
Richards, Karl Taylor, 564
Richardson, William Weise, 2066
Rinne, F. H., 1277
Rittenhouse, William Funk, 1062
Roberts, Harold H., 1379
Roberts, Joseph D., 1880
Roberts, William Miller, 1563
Robertson, Leslie L., 564
Robinson, Beverley, 2136
Robinson, William Pleasant, 564
Rocha, Ismael da, 1703
Rodd, Edwin, 2136
Rodman, Harry, 1627
Roff, Augustus Ward, 1214
Rogers, Albert Clark, 144
Rogers, George Augustus, 733
Rogers, Lewis Leonidas, 143
Rogers, William, 563
Rohn, John Phillip, 1062
Romine, George Lohman, 906
Rose, Daniel Albert, 1379
Rosen, Leo, 1982
Rosenow, Charles E., 907
Ross, Leonidas C., 648
Roth, F. F., 1979
Rothwell, William A., 907
Routledge, George Albert, 648
Rowe, Henry Boyden, 1880
Roy, Walter S., 811
Rubertone, Nicola, 321
Rucker, Wilford Ervin, 408
Rudberg, K., 220
Rueck, Gustav Adolph, 1063
Ruggles, Georgia Sackett, 2136
Rupert, Archibald M., 144
Russell, James William, 564
Russell, William George, 907
Russell, Wilmer W., 564
Ruthenberg, Erich Benno, 907
Ryder, Godfrey, 320

S

Sachs, Julius, 2067
Sackett, Clark D., 226
Saénz, Carlos Domingo, 1979
Safford, Leonard, 1711
Salm, William Kopp Tritle, 564
Sanderfur, John B., 1380
Sanders, John Franklin, 226
Sandifer, George Haywood, 1214
Sanor, Daniel Grant, 226
Sargent, Albert Alonzo, 1800
Sargent, Edward Sanborn, 811
Saul, E., 1277
Saulter, William Wallace, 907
Saunders, Percy Whittington, 226
Saunders, Walter E., 1379
Saurenhaus, Ernst, 487
Sauter, Charles F., 1982
Schaubel, George M., 144
Scheel, Victor, 402
Scheuer, Maurice M., 1563
Schilling, John Phillp, 1214
Schisler, Belle Augusta, 907
Schmidt, Richard M., 1982
Schmit, H., 43
Schneider, Charles, 563
Scholdager, Thoralf E. S. C., 1563
Scholl, Albert Louis, 1379
Schooler, James Knox, 734
Schuessler, Henry G., 564
Schultz, Guy A., 1628
Schulze, Carl A., 1283
Schütz, J., 645
Schweninger, Ernest, 402
Scott, Kimble R., 564
Scott, T. B., 804
Seeley, John Sanford, 1063
Selby, J. Algood, 2067
Seligman, Joseph Albert, 2136
Sell, Edwin Augustus, 321
Sellers, Robert B., 988
Sencert, Louis, 1132-1210
Shacklette, Jacob Patrick, 647
Shallenberger, James Nelson, 1563
Shannon, William Alexander, 1799
Shapira, Israel Jarius Elihaf, 321
Sharrer, Frank Leslie, 1982
Shattuck, Samuel George, 1876
Shaw, Gilman G., 564
Shaw, Lauriston E., 402
Shaw, Stremba, 1461
Shea, Daniel A., 563
Sheehy, Joseph Patrick, 1711
Sherrow, William E., 564
Shipps, William H., 2067
Shoop, C. I., 1711
Shugart, Floyd Caldwell, 2066
Shull, Harrison I., 1711
Sigworth, Harrison W., 1284
Silva, C. M., 1379
Simpson, Oscar Barre, 1800
Sizeranne, Maurice de la, 645
Skaggs, Charles Selmer, 407
Skelton, Harold A., 50
Sloan, Charles McLaughlin, 1063
Sloan, Milton Fackler, 1880
Smeltzer, William Finlay, 408
Smith, Anna Louisa, 811
Smith, Charles Harmon, 1800
Smith, Chester Owen, 144
Smith, D. Edmund, 144
Smith, Elbert H., 320
Smith, Matthew Marion, 407
Smith, Merrill Neville, 1213
Smith, Samuel F., 1380
Smith, Virginia Paine, 144
Smith, William Clive, 1461
Smith, William H., 1711
Snell, William Martin, 1563
Snyder, Edward W., 1628
Sokolowski, A., 1132
Somervill, Augustine Claiborne, 2136
Somerville, Harry, 50
Soubbotitch, Voislav, 1277
Soule, Robert Edward, 1710
Southworth, Benjamin Harry, 321
Southworth, Charles Wilson, 564
Souwers, George F., 1563
Speer, Anderson T., 647
Spencer, John R., 907
Spencer, William, 811
Spicer, Clarence E., 1214
Spielberg, 1277
Squire, Herbert A., 1215
Stallard, Samuel Lawrence, 906
Stanley, William Alexander, 733
Stanton, Byron, 143
Statham, John Richmond, 1137
Steadman, Charles Edward, 564
Steck, Charles T., 1283
Steiger, Emil, 144
Stephenson, Sydney H., 138

Sterling, John H., 1800
Stetson, Edwin Flye, 1982
Stevens, Anna C. R., 1628
Stevens, Charles Benjamin, 1800
Stevens, Serlah, 1563
Stewart, Charles B., 734
Stewart, Frank Manly, 1284
Stillman, William Olin, 1062
Stillwill, Hiram Read, 1460
Stirling, John William, 408
Stivers, Charles Clement, 1063
Stocks, William Henry Hobbs, 144
Stockton, Sarah, 1214
Stokes, Edgar William, 564
Stoffi, Floreano, 1380
Stone, Charles A., 50
Stone, Daniel Edward, 1379
Stone, Nell Elizabeth Ford, 2067
Stone, William Addison, 906
Stoops, Alexander Blair, 226
Stover, William Miller, 1460
Strait, Thomas Jefferson, 1563
Stratton, Robert Thompson, 2136
Stratz, C. H., 1621
Strawn, Enos King, 1062
Strickland, George, 906
Strickland, Marion Wilborne, 1284
Strickler, Charles Miller, 648
Strother, William H., 321
Strouss, Ulysses S., 1982
Stuard, Edward L., 488
Stuckey, Simon Fillmore, 1284
Stumpf, L., 138
Stunkard, Thomas Cromwell, 2066
Subotic, V., 642
Sugden, Charles Edward, 2136
Sullivan, William Bailey, 1461
Sultan, George, 321
Swan, Albert F., 1063
Swan, Charles Guy, 488
Swarzlzel, Joseph A., 50
Swett, George William, 1380
Swindle, William Thomas, 1380
Sykes, George Sherbourne, 1137
Sylvester, George Perry, 734
Sypert, William Edward, 1137

T

Taft, Jesse Winslow, 2067
Talbot, D. S., 2136
Talbott, Charles Worth, 226
Tanguay, John B. A., 2067
Tanner, Willis Canon, 1461
Tarleton, Marcus Breckenridge, 647
Telford, Norman, 408
Terrés, José, 804
Thatcher, John T., 906
Thayer, Addison Sanford, 50
Thomas, George Franklin, 2067
Thompson, Edward B., 1461
Thompson, James Goodwin, 907
Thompson, James H., 1563
Thompson, Marguerite E. B., 1880
Thomson, Alexis, 1132
Throckmorton, Charles Benton, 1214
Tigerstedt, R., 138
Tison, W. Walter, 1214
Titcomb, George Eugene, 50
Tittle, Carol Brock, 906
Tkadlec, Joseph, 1800
Todd, Elizabeth Anne, 811
Todd, William F., 320
Tooker, Robert Newton, 144
Torian, George, 321
Torrey, Arthur Stanley, 1461
Townsend, Richard Montague, 988
Trabert, John William, 2183
Trask, James Dowling, 2067
Trout, Albert L., 907
Trout, William A., 1380
Troutman, Rodney E., 1880
Tussey, A., Edgar, 2067
Tuttle, Jay, 144
Tutton, Henry V., 1563
Tweedy, John, 220
Tyler, Samuel M. Hooper, 2067
Tyrell, Adelaide Mary, 2136

U

Underwood, Francis Andrew, 408
Underwood, Sanford L., 143
Unger, L., 402
Urquhart, George W., 811

V

Vallin, E., 1057-1059
Vandeventer, Joseph, 1982
Van Dyke, Milton, 50
Van Hummell, Quincy, 408
Vanier, Felix P., 1284
Van Schaick, George Guy, 811
Velásquez, Manuel A., 138
Venard, John N., 1380
Verrall, Walter Sargeson, 408
Villada, Manuel María, 1979
Villaronga, Gabriel, 320
Vincke, G., 983
Von Malaise, E., 402

W

Wagner, Harold Frederick, 1460
Walcutt, Sherman, 488
Walker, Edmund Morton, 1799
Walker, Perry Green, 2067
Walker, William F., 734
Wallin, David Johnson, 1628
Walsh, John Emmett, 2136
Ward, Thomas J., 1711
Warnecke, Anna, 1880
Warren, Ernest Leighton, 1283
Wason, Eugene, 988
Watkins, Edward W., 1214
Watson, James A., 488
Watson, Washington D., 1283
Waylan, Julia Gould, 1214
Webb, William Burton, 564
Webster, William Butler, 1380
Wedd, Bernard H., 1057
Weeke, Paul H. F., 1062
Weidemann, Charles A., 811
Weidman, Stephen Yates, 144
Weidner, Samuel S., 1800
Weir, Samuel Dinwiddie, 2067
Weisman, Carl Herbert, 906
Welch, William Collin, 1880
Wellons, James W., 1284
Wells, Charles Augustus, 988
Wells, Elmer E., 734
Wells, Franklin Chamberlain, 144
Wells, Homer Leonard, 734
Werner, Frederick Charles, 408
Wessels, Asa L., 1284
Whaite, Herbert H., 1132
Wharff, Howard T., 1982
Whipple, Cullen H., 648
Whisman, Henry Stafford, 2136
White, Benjamin Walker, 1628
White, George Wallace, 1800
White, Peter Parrish, 321
White, Robert Allen, 1563
White, Samuel W., 320
White, William Henry, 564
Whitehead, Charles, 1214
Whitmore, Henry W., 1063
Whitney, William D., 1062
Whyte, G. Duncan, 43
Wicherski, Otto Gustav, 408
Wilcox, Frank H., 1379
Wilcox, Isaac Oliver, 988
Wilkie, John Notmans, 488
Williams, George Benjamin, 906
Williams, James Wright, 1982
Williams, John Wilson, 647
Williams, Thomas B., 1380
Williamson, Charles W., 2136
Williamson, James William, 408
Willis, George Stuart, 1213
Willson, Samuel Canby, 1628
Wilson, John Davis, 1628
Wilton, Isaiah, 408
Windham, Samuel H., 1711
Wingfield, William C., 1880
Winn, George Lamond, 2136
Winterberger, Edwin Ferdinand, 1880
Winters, Earle S., 143
Wintersteen, Grace, 1711
Wiseman, Osborn M., 2067
Wiskow, Adolph August Max, 144
Wittenberg, Louis William, 1283
Wix, George Brinton, 144
Wolpert, H., 1277
Wolski, Robert A., 1982
Womack, Arsey, 488
Wood, Milton Le Grand, 1062
Wood, William D., 811
Woodard, Daniel S., 320
Woodward, William Wellington, 407
Woodworth, Leonard P., 50
Worrell, Jonathan P., 906
Worthington, Joseph Kent, 50
Wright, George Alvin, 1628
Wright, Scipio Person, 1215
Wroth, James H., 1800
Wuest, Charles, 487
Wyatt, Finis E., 1880
Wyeth, Marlborough Churchill, 1880
Wyon, Guy A., 1132
Wythe, Stephen, 144

Y

Yarbrough, Landon Anderson, 907
Yoseph, Mirza Yoel, 408
Young, Charles C., 488
Young, J. H., 50

Z

Zacher, G., 901
Zaun, Henry H., 564
Zeigler, Charles Schuyler, 1628

E

EAR: See also under special structures of ear
EAR, congenital deficiency of otolithic apparatus, [Precechtel] 253—ab
labyrinth sign of serous meningitis, [Ferreri] 828—ab
tropical, [Forsyth] 1994—ab
EARACHE of laryngeal origin, control of, through nasal ganglion, [Clerf] *630
ECCHORDOSIS, spheno-occipital, [Stewart & Burrow] 582—ab
ECHINOCOCCOSIS: See also under names of organs and regions
ECHINOCOCCOSIS, differential diagnosis of, [Thiellé] 584—ab
echinococcus antigen, [Van der Hoeden] 831—ab
eosinophilia after skin tests for, [Bacigalupo] 166—ab
hydatids for complement fixation test, [Patterson & Williams] 824—ab
intradermal reaction in, [Giampaolo] 165—ab
stable antigen for complement fixation test in, [Patterson & Williams] 247—ab
ECHOLALIA, prolonged stage of, in child, [Pick] 2150—ab
ECLAMPSIA in nephritis of children, [Nobécourt] 1153—ab
is eclampsia a biologic necessity? [Gruhzit] 2079—ab
jaundice in, [Oppenheimer] 588—ab
nonprotein nitrogenous constituents of blood in, [Plass] *266
prophylactic treatment of, [Stroganoff] 1743—ab
treatment by bloodletting, [Salen & others] 1232—ab
treatment of, [Zweifel] 346—ab, [Gessner] 1235—ab
ECONOMICS, economy in care of sick, 1459
agreement not to practice within 20 miles, 1387—MI
ECZEMA and diathesis, [Bloch] 1089—ab
and sensitization, [Pulay] 2150—ab
calcium salts in, [Flamini] 249—ab
dry eczema of face, treatment of, [Moro] 1404—ab
in breast-fed infant, [O'Keefe] 1224—ab
in infants, [Rueda] 426—ab
in infants, constitutionally predisposed, treatment of, [Sokolow] 1155—ab
roentgenotherapy for, [MacDonald] 242—ab
sensitization in, [Jadassohn] 71—ab
EDEMA, sodium in dropsy, [Hausknecht] 584—ab
of leg, treatment of, [Pieri] 663—ab
pseudo-elephantiasis (familial generalized edema), [Harris] 237—ab
EDEMA, treatment of, [Lemierre & Lévesque] 1737—ab
treatment of renal dropsy, [Garofeano & Labin] 1154—ab
EDUCATION, higher, of parents, child mortality with reference to, [Lennox] 745—ab
EDUCATION, MEDICAL: See also Fellowships; Scholarships; Schools, Medical
EDUCATION, MEDICAL, [Diller] 1138—C, [van Rijnberk] 1660—ab, [Martin] 1721—ab
advantages of medical-surgical clinics in, [Miller] *1175
and culture, [Rushmore] 892—ab
annual congress on, 307—E, 798, 890, 972
basic principles of clinical teaching, [Cutter] 1070—ab
business of a university medical school, [Burton] *844
clinical teacher and medical curriculum, [Cushing] *841
clinics to first year classes, [Pepper] 1071—ab, [Pepper] *1632
cooperation between dental education and, [Banzhof] 892—ab
determination of content of professional and preprofessional training, [Capen] 1072—ab
experiment in interdepartmental correlation, [Joseph] 1071—ab, [Petersen] *2139
extension medical teaching, [Buiter] 891—ab, [Manning] 891—ab
graduates from French universities, 46
in 1909 and 1924, [Flexner] *833
increasing number of admissions to medical schools without increasing physical equipment, [Myers] 1072—ab
inferior medical teaching institutions, [Prior] 972—ab
Medical Diplomas: See under Licensure
methods of Sydenham (1624-1689), 1127—E
present needs of, [Colwell] *838
present opportunities for medical study in U. S., [Briggs] 972—ab
qualification of medical educator, [Funké] 740
restriction of demands in certain subjects to those things that are significant, [Edsall] 893—ab
school training of the physician, 1058
suggested reforms in medical curriculum, [Maes] *2007
suggestions on undergraduate curriculum, [de Schweinitz] 890—ab
university extension postgraduate medical education, [Meeker] 891—ab
EFFUSIONS, chlorid metabolism as gage of resorption of, [Delat] 2091—ab
retroperitoneal lymphocytoma causing chylous ascites and chylothorax, [Coley] *2031
EGG albumin as culture medium, [Goodrich] 1285—C, [Kagan] 1714—C
EGG, digestion of raw white of, [Rose & MacLeod] 578—ab
EINSTEIN, PROFESSOR, in honor of, 808
ELBOW, fracture of, from throwing ball, [Hazen] 499—ab
conservative treatment of old luxations of, [Weil] 1827—ab
fracture of, unusual, [Swanberg] *1932
ELECTRICITY, accidents due to, 1458
accidents, histopathology of vascular injury from, [Martin & others] 1236—ab
resuscitation from electric shock, 213—E
treatment of electric shock, [Jellinek] 345—ab
ELECTROCARDIOGRAPHY: See under Heart
ELECTROLYTES, distribution of, [Kraus & others] 1902—ab
in organism, [Kraus & others] 1901—ab
ELEPHANTIASIS, case of, from Belgian Congo, [Kellersberger] *1197
of scrotum, operation for, [Waller] 65—ab
pseudo-elephantiasis (familial generalized edema), [Harris] 237—ab
ultimate results of Kondoleon operation for elephantasic edema, [Kondoleon] 2087—ab
EMANOMETER, 729
EMBOLISM, air, [Bergstrand] 430—ab
in limbs, arteriotomy for, [Sencert] 67—ab
in renal artery, [Bull] 1310—ab
pulmonary, origin of, [Magnus] 830—ab
resulting from renal tumors, [Judd & Scholl] *873
treatment, [Lundberg] 1310—ab, [Perman] 2000—ab
EMBRYO, function-delaying element in embryonal development, [Bok] 668—ab
EMETIN polyneuritis, [Bonorino Udaondo & Carulla] 754—ab
and amebiasis, 1782—E
EMIGRATION and immigration; Belgium, 49
EMPHYSEMA, subcutaneous, following tonsillectomy, [Rosenbaum] *2119
EMPLOYER'S LIABILITY: See Workmen's Compensation
EMPLOYMENT in fundamental sciences, registration bureau for, [Edmunds] 1065—C
EMPYEMA, acute, operation for, [Pickhardt] 823—ab
nontuberculous, [Heuer] 576—ab
pleural, [Hansen] 430—ab, [Suermondt] 1158—ab
pleural, chronic, [Murstad] 1310—ab
treatment of, [McGlannan] 234—ab, [Bettman] *359
treatment, valve pleurotomy, [Tourneix] 1899—ab
treatment with gentian violet, [Davis] 60—ab
tuberculous, conservative treatment of, [Stahl & Bahn] 73—ab

ENCEPHALITIS, EPIDEMIC, [McIntosh] 1065—C, 1704
and poliomyelitis, [Neustaedter & others] 580—ab
basal ganglions affected in, [Oliver] 1297—ab
basal metabolism after, [Stevenin & Ferraro] 828—ab
cause of, 1913—ab
cerebrospinal fluid in, [Foster & Cockrell] 1991—ab
chronic, from medicolegal standpoint, [Wimmer] 1576—ab
diagnosis, tuberculous meningitis simulating epidemic encephalitis, [Bernstein] *1915
etiology of, [Jahnel & Illert] 71—ab
etiology, specificity of streptococci in etiology of diseases of nervous system, [Rosenow] *449
familial acute epidemic, [Ebaugh] 1223—ab
histology of nervous system in, [DaFano] 824—ab
histopathology of poliomyelitis and, [Hassin] 497—ab
in England, 2130
in Peru, [Espejo] 68—ab
nephritis in; diagnosis from myoclonic uremia, [Bennett] *957
prevalence of, 1560, 2061
pupillary reactions in, [Mehrtens & Barkan] 242—ab
sequels, [Comby] 1004—ab, [Duncan] 1896—ab
sequels, basal metabolism and postencephalitic states, [Van Bogaert] 2143—ab
sequels, brain in parkinsonism, [Lucksch & Spatz] 73—ab
sequels, dystonia musculorum with equinovarus following, [Goodhart & Kraus] 1475—ab
sequels, etiology of respiratory arrhythmias following encephalitis, [Rosenow] 918—ab
sequels, organic behavior in parkinsonian syndrome, [Mackenzie] 582—ab
sequels, postencephalitic parkinsonism, [Burghi] 342—ab
sequels, postencephalitic myoclonia of diaphragm, [Haibron & Gambillard] 1152—ab
sequels, torsion spasm after, [Bing & Schwartz] 1084—ab
sequels, treatment of encephalitic parkinsonism, [Hennes & Barsch] 200—ab
skin lesion in, [Smith] 1149—ab
sodium nucleinate in, [Leiner] 420—ab
streptococci as cause of, [Rosenow] 1648—ab
symptoms of, 721—E
treatment of, [Wilson] 60—ab, [Rathery & Gournay] 1821—ab
virus of herpes and, [Bastai & Busacca] 830—ab, [Parker] 2083—ab
with painful abdominal spasm, [Hall] 1480—ab
ENCEPHALITIS, EXPERIMENTAL, [Silberstein] 666—ab
ENCEPHALITIS, SPONTANEOUS, of bacterial origin, [Goodpasture] 1648—ab
of rabbits, [Doerr & Zdansky] 503—ab
ENCEPHALOMYELITIS, fulmination, [Meleney] 242—ab
ENDARTERITIS obliterans, cholesterolemia in, [Heitz] 239—ab
ENDOCARDITIS, infectious, chronic, [Syllaba] 589—ab
bacterial, [Thayer] 1721—ab
malignant, with typhoid symptoms, [Laubry & Walser] 1401—ab
rheumatic, [John & Nobel] 666—ab
slow, in children, [Acuña & Casaubon] 427—ab
subacute bacterial, [Clawson] 1076—ab, [Graham & others] 1721—ab
subacute infective, aortic lesions of, [Grant] 1836—ab
ENDOCRINES, action of hormones, [Zondek & Reiter] 1090—ab, [Zondek] 1485—ab
and phagocytosis, [Asher] 1088—ab
deficiency of, and avitaminosis, [Abderhalden] 1007—ab
derangement and osteochondritis, [Lieschied & Seilheim] 2092—ab
disorders, bone development in, [Engelbach & McMahon] 1078—ab
disturbances and glaucoma, [Lagrange] 1655—ab
endocrine organs, [Kingsbury] 1078—ab
standardizing the hormone, 967—ab
therapy, intravenous use of organ extracts, 1332—ab
therapy, value of, [Gow] 1895—ab
ENDOMETRIOMYOMA of pregnant uterus, [Lochrane] 246—ab
ENDOMETRIUM, implants of, in peritoneal cavity, [Sampson] 1299—ab
autoimplantation of, [Lauche] 2091—ab
relation of, to ovarian function, [Norris & Vogt] 657—ab
ENDOTHERMY in accessible neoplastic diseases, [Wyeth] 1643—ab
in malignant disease, [Wyeth] 821—ab
ENDO-OVARINA TABLETS not accepted for N. N. R., 2068—P
ENTERITIS, balantidium, [Brandt] 343—ab
ENURESIS: See under Urine, incontinence
ENVELOPS, sterilization of, 991
ENZYMES: See under Ferments
EPENDYMA, carcinoma of, [Warfield] 156—ab
tumors arising from ependymal cells, [Bailey] 496—ab
EPIDEMICS, control of, 1447—E
in Greece, fight against, [Gautier] 1827—ab
in Russia, 1136
EPIDIDYMITIS, surgical pathology of, [Kretschmer & Alexander] 62—ab
tuberculous, [Hunt] 2081—ab
EPILEPSY, action of epileptic serum on arteries, [Meyer] 170—ab
acid-base mechanism in, studies of, [Geyelin & others] 1988—ab
bilateral Jacksonian, [Löwy & Potzl] 73—ab
blood calcium deficiency in, [Bigwood] 926—ab
blood in, nonprotein nitrogen in, [Lennox & others] 497—ab
blood in, physical-chemical balance of, [Bigwood] 1481—ab
blood sugar in, [Holmström] 590—ab, [Daly & others] 1002—ab
calcification of ventricle wall causes, [Taft] 240—ab
diagnosis of, 813
early convulsions in epileptics and in others, [Patrick & Levy] *375
in children, [Gareiso] 1738—ab
in parrots, [Allende-Navarro] 662—ab
marriage not annulled for concealing epilepsy, 1069—MI
myoclonus, [Lobstein] 1660—ab
partial continuous epilepsy, [Wilson & Winkelman] 1814—ab
relation of adherent prepuce to, [Block] 1812—ab
seizures with retained consciousness, [Marchand] 1655—ab
status epilepticus at childbirth, [Burger] 1235—ab
surgical treatment of, [Clark] *770
toxicity of serum in, [Pagniez] 662—ab
treatment, drugs in, 1521—ab
treatment, phenobarbital in, [LaRue & Thornburgh] 419—ab
treatment, protein, [Weidner] 1999—ab
treatment with bromids, 325, [Ulrich] 663—ab
EPINEPHRIN, absorption of, [Lyon] 335—ab, 473—E
and capillaries, [Manfredi] 425—ab
effect of asphyxia on action of, [McCarrison] 1651—ab
Epinephrin-Wilson, 631
idiosyncrasy to, [Symes-Thompson] 1735—ab
intracardiac injection of, in operative syncope, [Petit-Dutaillis] 502—ab
output, influence of ether on, [Kodama] 1576—ab
reaction to, [Lyon] 66—ab
restriction of rate of flow and interchange in capillaries by vasoconstrictor drugs, [Douglas] *381
sensitivity to, in hypertension, [Hetényi & Sümegi] 830—ab
spleen and epinephrin lymphocytosis, [Robitschek & Selinger] 252—ab
EPIPHYSES, calcium deposits in, [Tisdall & Erb] 575—ab
of femur, spontaneous separation of, [Zaaijer] 1235—ab
studies on, [Sullivan & others] 1816—ab
tumors in, [Hinman & Gibson] 822—ab
EPISCLERITIS, recurring, [Heinonen] 1010—ab
EPISTAXIS: See Nose hemorrhage
EPITHELIOMA, adamantine, of jaw, [Horsley] 1393—ab
erythematoid benign, [Little] 421—ab
of orbit, [Heltor Praguer Fróes] 1822—ab
of skin, creosote causes, [Cookson] 1228—ab
EPITHELIUM, surviving, [Ebeling] 1402—ab
EPITROCHLEAR GLANDS: See Lymph Nodes, epitrochlear
EREPTON, feeding with protein cleavage products, [Levy] 757—ab
ERGOGRAPHY, clinical, [Lehndorff] 170—ab
ERGOT ASEPTIC, 303
ERGOTAMIN pupil reaction, [Zunz] 1230—ab
ERUPTION: See Exanthem
ERYSIPELAS, [Laache] 430—ab
convalescent serum in, [Jordan & Dustin] *874, [Zingher] 1217—C
migrans, treatment of, 569, 912
ERYTHEMA induratum, [Alderson] 746—ab
infectious, [Brusa] 1998—ab
macular, following trauma of abdomen, [Rasch] 1994—ab
nodosum, etiology of, [Coglievina] 1903—ab
nodosum with tuberculous bacillemia, [Watt & Stubbs] 1301—ab
ERYTHREDEMA: See Acrodynia
ERYTHREMIA: See Polycythemia
ERYTHROCYTES and altitude, 720—E
auto-agglutination of, [Mino] 1006—ab
colorless, [Fahræus] 932—ab
effect of hemorrhage, transfusion and irradiation on production and maturation of, [Isaacs] 2078—ab
hemoglobin and cell volume in children, [Drucker] 254—ab
iron treatment and oxygen consumption of, [Roessingh] 1826—ab
ERYTHROCYTES, osmotic resistance of, [Simmel & Simmel-Rapp] 755—ab, [van Paassen] 1236—ab, [Acel] 2149—ab
phagocytosis of, in pernicious anemia, [Peabody & Broun] *963
poikilocytes in normal blood, [Huck & Bigalow] 157—ab
sedimentation in moving blood stream, [Berczeller & Wastl] 830—ab
sedimentation, micromethod for estimation of, [Linzenmeier & Raunert] 2000—ab
sedimentation of, in psychiatry, [Glaus] 1403—ab
sedimentation test, [Hildebrandt] 1485—ab
sedimentation test and globulins, [Salomon] 1487—ab
sedimentation test in pneumothorax, [Schneider] 74—ab
sedimentation test in surgical diagnosis, [Friedlaender] 1143—ab
shadows of, after transfusion, [Van der Hoff] 1736—ab
sugar in, under insulin, [Wiechmann] 756—ab
suspension stability of blood from surgical standpoint, [Haller] 342—ab
technic for counting, [Christensen] 170—ab
types, agglutinin differentiates 2 types of group II erythrocytes, [Huck & Guthrie] 747—ab
vitamins and blood, [Jonas] 73—ab
ERYTHROMELALGIA and Raynaud's disease, [Nobécourt] 1402—ab
ESOPHAGITIS with hematemesis, 1707
ESOPHAGUS, artificial, [Saier] 1083—ab
cancer of thoracic esophagus, [Bérard & Mallet-Guy] 1822—ab
cancer, radiation in, [Case] 240—ab
caustic poisoning and Saizer method of treatment, 1060
dilation of, in cardiospasm, [Vinson] 1227—ab
diverticulum perforating into lung, healing of, [Frey] 1009—ab
pain, nature of, [Payne & Poulton] 66—ab
perforation of, by instruments, [Friedenwald & Morrison] 1143—ab
primary sarcoma of, [Smith & Rusk] 241—ab
spasm of, [Schlesinger] 429—ab
stricture, flexible sound for intubating esophagus, [Souttar] 1995—ab
syphilis of, [Guisez] 1996—ab
ETHER, influence of, on epinephrin output, [Kodama] 1576—ab
absorption and elimination of, [Haggard] 1892—ab
absorption, studies on, [Haggard] 1892—ab
Anesthesia: See Anesthesia
anesthetic action of, [Haggard] 1892—ab
effect of addition of, to blood, [Austin & Gram] 1891—ab
ETHICS, curious case of alleged professional indiscretion, 2135
ETHMOID BONE, malignant tumors of, [Chatellier] 927—ab
ETHYLENE for coloring citrus fruits, 787—ab
Anesthesia: See under Anesthesia
EUGENICS, breeding from worst stock, 221
alcohol factor in eliminating racial degeneracy, [Stockard] 1737—ab
ban on marriages of poverty, 1793
studies on genetics, 405
EUSCOPE as an aid to microspy, [Exton] *1838
EVIDENCE: See also Testimony
EVIDENCE, 1221—MI
expert, 818—MI
state furnishing impure vaccine; hearsay report, 1386—MI
EXAMINATIONS, leaving adjustments to patient—making few examinations, 416—MI
EXANTHEM from bathing, [Naegeli] 341—ab
etiology of exanthematous diseases, [Amato] 68—ab
nature of, [Admanson] 659—ab
EXERCISES to strengthen intra-abdominal organs, [Laurka] 248—ab
EXHAUSTION and septicemia, [Crile] 1224—ab
EXHIBITS of ministry of health at British Empire Exhibition, 1373
EXPLOSION of machine used in anesthetizing, injury to patient from, 329—MI
EXTRAPYRAMIDAL AFFECTIONS, [Jacob] 2092—ab
EXTREMITIES: See also Arm; Leg
EXTREMITIES, gangrene of, complicating puerperal sepsis, [Chesky] 658—ab
surgery of spine and, [Taylor] 1381—C
EXTUBATION, digital, simple method of, [Leshure] *631, 1065—C, [Clemens] 1065—C
EXUDATES and transudates, [Borgherini-Scarabellin] 2088—ab
EYE: See also under Special Structures of Eye
EYE abnormality, hereditary, caused by roentgen ray, [Bagg & Little] 1570—ab
affections of, in silk factories, 808
artificial, cartilage as base for movable ocular prosthesis, [Magitot] 927—ab
disease, parenteral protein therapy in, [Pollice] 1998—ab
diseases, milk injections in, [Stevenson] 159—ab, [Moore] 923—ab, [Newman] 1389—ab

EYE, dislocation of eyeball at birth, [Gerdes] 1233—ab
foreign bodies in, [Aubaret] 927—ab
fundus, necropsy findings in, [Rulmer] 1301—ab
infections, antidiphtheric serum in, [Key] *183
inflammation caused by dental sepsis, [Jones] 63—ab
intra-ocular pressure as molecular concentration of blood is modified, [Weekers] 585—ab
intra-ocular pressure, vascular hypertension increases, [Adler & others] 1890—ab
loss of, affording only perception of light, 234—MI
microscopy of, [Vogt] 165—ab
microscopy, with Gullstrand slit lamp and corneal microscope, [Bedell] *363
paralysis, chronic progressive ophthalmoplegia, [Pelnár] 1576—ab
senile and myopic eyeball, [Vogt] 2088—ab
surgery, insulin and surgery of eye in diabetics, [Nicheiatti] 1998—ab
surgery, protargin strong as a preoperative prophylactic, [Reese] *1593
syphilitic disease of, [Seguini] 828—ab
EYELID, xanthoma of, [Nobl] 344—ab
dermoid of, [Gradle & Stein] 1890—ab

F

FACE, facial characteristics of gallbladder, ulcer, tuberculosis, pernicious anemia and nephritic hyperirtension patients, [Draper & Dunn] 1989—ab
paralysis: See Paralysis, facial
FALLOPIAN TUBES, inflation of, with carbon dioxid gas, [Burch] 1469—ab
insufflation of, [Dührssen] 1902—ab
insufflation, use in sterility of antispasmodic drugs in combination with transuterine insufflation of gas, [Meaker] *2098
patency, testing of, [Heaney] 240—ab, [Currier] 925—ab, [Sellheim] 1406—ab
patency, possibility of infection from Rubin test, [Volkmann] 1156—ab
patency, transuterine insufflation of gas in sterility, [Meaker] 1077—ab
pyosalpingitis with adhesions, operative technic in, [Roussiel] 2088—ab
rupture of pyosalpinx, [Huet] 1304—ab
tumors, primary, [Müller] 1744—ab
FAMILIES, small, increase in number of, 1709
FASCIOLA hepatica, obstruction of common bile duct by, [Maury & Pélissier] 1304—ab
FASCIOLOPSIS buski infection, [Lal] 581—ab
FASTING animals, action of serum from, [Carnot & Terris] 1653—ab
contents of fasting stomach, [Weltz & Fischer] 1741—ab
intussusception following, [Mooro] 1150—ab
liver changes in fasting animal, [Rous & McMaster] 1396—ab
muscles after insulin and fasting, [Kühn & Baur] 1999—ab
FAT intoxication, [Allen] 1476—ab
fat tissue necrosis, [Schweizer] 1403—ab
metabolism of, [Vanÿsek & Kaufmann] 758—ab
metabolism of, and vitamin A, [Hamburger & Collazo] 71—ab
metabolism, rôle of cholesterol in, [Bloor] 1891—ab
FECES, acidity of infants' stools, [Tisdall & Brown] 1473—ab
bacteria in, food, stools and bacillus bifidus, [Rihle] 1155—ab
determination of stercobilin, [Pietra & Bozzolo] 1305—ab
"long bacilli" of, [Weiss] 1824—ab
organic acids in fermentation in stools, [Roux & Goiffon] 1303—ab
FEEBLEMINDEDNESS, syphilis as factor in etiology of mental deficiency, [Weiss & Izgur] *12
care of feebleminded in institutions in U. S., 1191
instruction of backward children, 1707
FEES and insurance companies, 1060
condemnation of dichotomy, 1278
disease—a luxury, 1798
employment of physician for employee of corporation, 1720—MI
Hochenegg's attack on profession; verdict of disciplinary court, 2063
specified fees, contracts for, and "no cure, no pay," 1987—MI
wheat valorization of, in Hungary, 405
FEET: See Foot
FELLOWSHIPS, medical fellows of National Research Council, 229
postgraduate, 1210
FEMUR, epiphysis of, spontaneous separation of, [Zaaijer] 1235—ab
fracture of, [Bartley] 1468—ab
fracture of, acute flexion of leg on thigh position in, [Byford] 1817—ab
fracture-dislocation, unusual case of, [Harris] *1608
fracture of neck of, function of limb after, [Fossataro] 753—ab
FEMUR, fractures of, nonoperative treatment of, [Meyerding] 1649—ab
fractures of neck of, operative treatment, [Hildebrand] 932—ab
secondary hypernephroma in, [Broster] 63—ab
FERMENTS, defensive, [Küster & Bode] 70—ab
material from which ferments are formed, [Jacoby] 427—ab
proteolytic, of serum, [Okubo] 1158—ab
FERNET DE VECCHI, 989—P
FERRASSIN, 1712—P
FERTILITY and Nutrition: See Reproduction
FETUS, action of roentgen rays on, [Peralta Ramos & Bazán] 1573—ab
calcium content of, [Schmitz] 505—ab
death of, carbon monoxid causes, [Phillips] 659—ab
death of, carried past term, [Mayer] 667—ab
heart sounds, to reenforce, [Schaffer & Fleischer] 667—ab
intra-uterine crepitation on fetal head, [Ottow] 1235—ab
prenatal pathology and morbid heredity, [Vignes] 1304—ab
FEVER and fat tissue, [Czerny] 1404—ab
amino-acids in, [Donath & Heilig] 2092—ab
and arthropathies of protein origin, [Bezançon & others] 1997—ab
diet in, [Weckerling] 2150—ab
fat content of blood in, 1801
fever late in possibly unrecognized syphilis, [Bloch] 2088—ab
of central origin, [Franz] 1574—ab
FIBROBLASTS, survival and growth of, in vitro, [Carrel & Ebeling] 61—ab
FIBROGLIOMA of root of nose, [Rocher & Angiade] 1655—ab
FIBROID: See under names of organs
FIBROMAS: See also under names of organs as: Uterus, fibromas
FIBROMAS in nasopharynx, [Alonso] 68—ab
peri-articular, of skin, [Savatard] 1475—ab
FIBULA, shifting, to substitute tibia, [Fiori] 504—ab
transplant to replace tibia, [Fieschi] 1738—ab
FILARIA bancrofti, case of elephantiasis from Belgian Congo, [Kellersberger] *1197
FILIPINOS, blood sugar content of, [Concepcion] 580—ab
FILMS: See Motion Pictures
FINGERS, hippocratic, [Campbell] 924—ab
FIRMA-CHLADNI, 51
FIRST AID, emergency medical service, 1457
FISH, salted, red discoloration of, 315
FISSURE, anal, high-frequency current in, [Delherm & Savignac] 1231—ab
FISTULAE, [Pels Leusden] 1485—ab
cervical, lateral, [Christopher] 1300—ab
gastro-intestinal, spontaneous healing of, [Heuse] 1744—ab
gastrojejunocolic, [Stenhouse] *1926
jejunal, [Lehman & Gibson] *1918
pilonidal sinus (coccygeal fistula), [Stone] 234—ab
tuberculous, treatment of, with copper sulphate, [Franke] 1069—ab
FLOODS, public health measures adopted following, 485
FLUMERIN in syphilis, [Snodgrass] 824—ab
Flumerin-H. W. & D., 469
FLUORID origin of goiter, [Goldemberg] 427—ab
FOOD: See also Diet
FOOD and clothing as factors in school life, 1458
and satiety, 632—E
dynamic action of [Abelin] 428—ab, [Bernhardt] 1090—ab
"eat more" campaigns, 718—E
hygiene, inspection of foodstuffs, 1376
hygiene, medical examinations for handlers of food products, 330—MI
infection due to paratyphoid bacillus, [Salthe & Krumwiede] 745—ab
poisoning from cakes, 1706
poisoning, outbreak of, near Vienna, 1708
requirement in children, [Hintze] 252—ab
selective effect of food scarcity on aged persons, 1879
FOOT, arch supports, their abuse and proper indication, [Gottlieb] *295
cramps in feet, 148
deformities, nail-fixation in operative correction of talipes varus, [Elmer] 1405—ab
deformities, mechanism of flatfoot, [Morton] 1817—ab
deformities, recent literature on flatfoot, [Feltesohn] 1659—ab
deformities, treatment of claw foot, [Stuart] 1817—ab
deformities, treatment of congenital club foot, [Geist] 920—ab
displacements of, and weight bearing, [Patterson] 1470—ab
drop-foot, brace for, [Galland] *30
evolution of human foot, [Morton] 920—ab
gangrene of, in infant, caused by cardiac lesion, [Hoopman] 1897—ab
FOOT AND MOUTH DISEASE, epizootic of, 560
in England, 314
in man, [Gerlach] 1234—ab
FORCEPS, new, for cystic duct, [Behrend] *875
in Labor: See Labor
FOREIGN BODIES: See also under organs and regions
FOREIGN BODIES in infratemporal space, [Friesen] *1693
negligent treatment of hand for broken needle—testimony of attendant, 233—MI
FORGING name of physician to prescription, 1386—MI
FORGUE, PROFESSOR, in honor of, 1134
FORMALDEHYD, production of, by intestinal bacteria, [Shaw] 1399—ab
aldehyd in phenomena of microbian antagonism, [Müller] 1898—ab
FOSFOFLASMINA not accepted for N. N. R., 2068—P
FOUCHET TEST: See Urine, bilirubin in
FRACTURES: See also under names of bones
FRACTURES, compound, results of treatment of, [Cook] 926—ab
artificial relaxation of muscles in, [Moser] 2091—ab
glue for traction in, 2069
leaving adjustments to patient—making few examinations, 416—MI
need not submit to operation to correct bad union of fractured femur, 1466—MI
of leg with great displacement, [Sommer] 829—ab
of one bone not complete fracture of arm, 1293—MI
reconstruction of fractured shaft of bone in leg, [Baudet & Masmontell] 340—ab
treatment, electricity in, [Heald] 1995—ab
treatment of, [Wilkie] 1994—ab
treatment, skate in fracture of lower extremity, [Yergason] 1478—ab
treatment, use of plaster cast—complications—liability, 1293—MI
ununited, [Campbell] 1471—ab
FRAMBESIA, campaign against, in Dutch East Indies, [Winckel] 685—ab, 1458
FRANCE, Association for Development of Medical Relations Between France and Allied Countries, 223
birth and death rates in, during last hundred years, 1561
medical graduates from French universities, 46
needy foreigners and free medical care, 729
number of students attending universities of, 807
practice of medicine by agrégé professors, 1623
suppression of ministry of public health, 1375
vital statistics for large cities of France, 1923, 730
FRIENDS OF MEDICAL PROGRESS, INC., 1203—E, [Gordon] 1630—C
FRÖHLICH'S SYNDROME: See Dystrophy, adiposogenital
FRUITS and gastric secretion, [Pavlovic] 664—ab
ethylene for coloring, 787—ab
systematic fruit courses in treatment, [Mendel] 1741—ab
viability of intestinal bacteria in, [Vasquez-Colet] 1149—ab
FURS, dermatosis from, 307—E
FURUNCULOSIS of external ear, [Leroux] 927—ab
of nose, [Tolan] 750—ab
on face, malignant, treatment of, [Friedemann] 507—ab

G

GALLBLADDER, calcareous gallbladder wall, [Fowler] 241—ab
calculi, [Hubbard] 1146—ab
calculi, acute, inflammation from, [Livingston] *1495
calculi, and roentgenograms, 1211
calculi, causes of, [Drury & others] 1396—ab
calculi, experimental, [Rous & others] 999—ab
calculi formation and reaction of bile, 1127—E
calculi, ileus from gallstone in intestine, [Bonnecaze & LeChaux] 1821—ab
calculi, in children, [Fischer] 2149—ab
calculi, inflammation causes, [Rous & others] 999—ab
calculi, participation of liver in, [Tietze & Winkler] 1657—ab
calculi, recurrent, [Decker] 746—ab
calculi, relation of pancreatitis to, [Fallon] 1394—ab
calculi, treatment of, [Théohari] 248—ab
calculi vs. gastro-intestinal affections, [Meulengracht] 1307—ab
disease, acute obstructive, [Morley] 1399—ab
disease, biliary obstruction following cholecystectomy, [Judd & Burden] 1645—ab
disease, glycosuria in, [Lichty & Woods] 745—ab
disease in young persons, [Eusterman] 1474—ab
disease, incidence of diabetes in, [Rabinowitch] 1646—ab
disease, cardiac irregularities and operability of cholelithiasis and cholecystitis, [Straus & Hamburger] *706, [Behrend] 990—C
disease, roentgenologic diagnosis of, [Carman & others] 1000—ab

GALLBLADDER disease, studies in human constitution, [Draper & others] *431
drainage, knotting of duodenal tube during, [Boles] *303
drainage, medical, [Sachs & others] 1474—ab
excision, cholecystostomy vs. cholecystectomy, [Deaver & Reimann] *2115
excision, contraindications to, [Gibbon] 746—ab
excision with primary suture, [Hofmeister] 428—ab
inflammation without jaundice, bilirubin determination in, [Friedman & Straus] *1248
inflammation, chronic, without stone, [Bancroft] 241—ab
research on, [Halpert] 1658—ab
roentgenologic examination of; intravenous injection of tetrabromphenolphthalein, [Graham & Cole] *613, [Graham & others] *1777
stasis and colic, [Zander] 73—ab
surgery, cholecystostomy vs. cholecystectomy, [Deaver & Reimann] *2115
surgery, cholecystostomy with tube and possibility of valve formation, [Wise] *1936
surgery of, [Martin] 1393—ab, [Wise] 1810—ab
surgery, exposure in, [Holman] *1045
surgery, prognosis in, [Judd] 1396—ab
surgery, simple substitute for ordinary sandbag in, [Judd] *1199
surgical conditions of ducts and, [Bryan] 1476—ab
GALL-DUCTS: See Bile Ducts
GALLSTONE: See Gallbladder calculi
GANGLIONEUROMA of cervical and thoracic sympathetic ganglions, [Stout] *1770
GARIEL, C. M., death of, 1375
GARLIC, action of insulin and, [Mahler & Pasterny] 1485—ab
GAS: See also Mustard Gas
GAS bacillus infection, recovery from, [Page] 426—ab
chimney, action of, [Stoklasa] 2150—ab
poisoning, war, sequelae of, [Brelet] 248—ab, [Dautrebande] 1503—ab
GASOLINE, toxicity of, 2138
GASSERIAN GANGLION radicotomy, 318
removal of, [Krause] 344—ab
resection of, 731
GASTRIC JUICE: See Stomach secretion
GASTRIN in gastric and duodenal mucosa, [Ivy & Oberhelman] 997—ab
GASTRO-ENTEROSTOMY opening, cicatricial obliteration of, [Delore & others] 1083—ab
double, for hour-glass stomach, [Gibson] 241—ab
GASTRO-INTESTINAL TRACT disease: See also Digestion disturbances; Dyspepsia; Nutrition
and kinks of ureter, [Webb-Johnson] 1819—ab
disease, [Citron] 664—ab, [Alessandrini] 1483—ab
disease and mental disorders, [Henry] 2145—ab
foreign body, swallowed shawl pin, [Fabricius-Møller] 1904—ab
hemorrhage in tabes, [Pollakoff] 1576—ab
multiple polyposis of, [Struthers] 2146—ab
pathology of digestive system in 1924, [Carnot & Gaehlinger] 1654—ab
surgery, complications caused by ascarids after, [Haim] 1903—ab
GASTROPTOSIS: See Splanchnoptosis; Stomach, ptosis
GASTROSCOPY and exploratory laparotomy, [Hammesfahr] 1157—ab
in diagnosis, [Elsner] 1824—ab
new method for introduction of gastroscope, [Heisley] *207
GATÉ AND PAPACOSTAS' REACTION, formaldehyd serum reaction, [Dazzi] 1900—ab
GAUDUCHEAU ointment, formula and value of, for prophylaxis of venereal diseases, 812
GENITALS, female, epidemic gangrene of, [Stephansky] 1484—ab
avulsion of scrotum and penis, [Cottle] 1894—ab
male, tuberculosis of, [Sussig] 1088—ab, [Wallner] 1659—ab, [Sussig] 2148—ab
method of examining secretions obtained by massage from prostate, seminal vesicles and ampullae of vasa, [Boyd] *792
GENITO-URINARY TRACT: See also Bladder; Genitals; Urinary Tract; etc.
GENITO-URINARY TRACT, treatment of surgical tuberculosis of, [Hunt] 237—ab
GENTIAN VIOLET in treatment of empyema, [Davis] 60—ab
intravenous injections of, in septicemia and local infections, [Young & Hill] *669
GERMANY, aiding German intellectuals, [Knopf] 649—C
American aid for German medical science, [Schwalbe] 829—ab
attendance at German universities, 1378
conditions among Berlin school children, 319
dismissal of officials and teachers in, 49
hard times and abortions in, [Bumm] 545—ab
infant and child mortality in Germany, 1913-1922, 810
loss of weight among German population, 1626
GERMANY, separate tables for physicians, 486
solicitor for funds for German physicians not authorized, 1791
Surgery, German Surgical Society, annual meeting of, 342—ab
tuberculosis in, increase in, 142
vital statistics of, 142, 486
GERMICIDES, recent progress in, [Young] 236—ab
GLANDERS, 646
GLAUCOMA, [Dotson] 1389—ab
acute, treatment of, [Heimann] 2150—ab
and endocrine disturbances, [Lagrange] 1655—ab
diagnosis of, [Chevallereau] 927—ab
endocrine origin of, [Imre] 1890—ab
technic of iridectomy done under conjunctival flap for, [Reese] *614
treatment of, [Hamburger] 1233—ab
GLIOMA, cystic, in brain, surgical treatment of, [Martin] 67—ab
gliomatosis of leptomeninges, [Firor & Ford] 1730—ab
GLOBULIN, crystalline, precipitin reactions of, from human urine, [Everett & others] 157—ab
distribution of albumins and, [Gutzeit] 664—ab
GLUCOSE, hypoglycemic symptoms provoked by repeated glucose ingestion in renal diabetes, [Gibson & Larimer] *468
injections and ether anesthesia, [Kutscha-Lissberg] 830—ab
serum, nature of, [Thannhauser & Jenke] 1156—ab
GLUE for traction in fractures, 2069
GLUTEAL REGION, surgical anatomy of, [Ssokoloff] 70—ab
GLYCERIN, stimulation treatment with, [Magat] 755—ab
GLYCOGEN, Yastarini-Cresti stain for, [Voorhoeve] 1488—ab
GLYCOKININ, action of, [Gottschalk] 1901—ab
GLYCOSURIA: See also Diabetes; Urine, sugar in
GLYCOSURIA, alimentary, in nephritis, [Hetényi] 1234—ab
and ascites, [Loeper & Turpin] 2088—ab
caffein, [Gautier] 1083—ab
chronic, [Hsu] 1828—ab
estimating small amounts of glucose in urine, [Williams & Casey] 1227—ab
in pregnancy, [Rabinowitch] 2081—ab
nervous lesions and diabetes, [Camus & others] 1584—ab
relation of, to kidney permeability, [John] 418—ab
GLY-SO-IODONATE, 1881—P
GNAT BITE, severe illness from, [Roberts] 1399—ab
GOITER: See also Hyperthyroidism; Hypothyroidism; Thyroid
GOITER and iodin, 795—E
and mental disorders, [Foss & Jackson] 1992—ab
and tuberculosis, [Hoffmann] 252—ab
auricular fibrillation in, [Baumgartner & others] 1729—ab
congenital, [Skinner] *1190
endemic, in British Columbia, [Keith] 1646—ab
endemic, iodin in prophylaxis of, [Roch] 1997—ab
endemic; its prevention, [Kimball] 1568—ab
exophthalmic, [Bittorf] 1739—ab
exophthalmic, acute, [Manginelli] 586—ab
exophthalmic, and insulin, 1877
exophthalmic, causes corneal ulcer, [Hinton] 1645—ab
exophthalmic, gastric secretion in, [Herzfeld] 343—ab
exophthalmic, history of, 644
exophthalmic, insulin in, [Lépine & Parturier] 1152—ab
exophthalmic, iodin in, [Plummer & Boothby] 919—ab, [Starr & Means] 1989—ab
exophthalmic, iodin, solution in, (Lugol's) [Mason] 1394—ab
exophthalmic, operative treatment of, [Lieblig] 1657—ab
exophthalmic, persistent thymus in, [Frassi] 341—ab
exophthalmic, prognosis of operations for, [Troell] 932—ab
exophthalmic, radiotherapy of, [Gutiérrez] 1824—ab
exophthalmic, radium treatment of, [Butler] 250—ab
exophthalmic, roentgenotherapy of, [Goodwin & Long] 745—ab
exophthalmic, share of thalamencephalon in, [Waldorp] 99—ab
exophthalmic, spontaneous cure of, [Hyman & Kessel] 822—ab
exophthalmic, treatment of, 970—E
in Bavaria, [Pfaundler & Wiskott] 344—ab
in Swiss recruits, [Stiner] 1900—ab
incidence, increased frequency of, [Lämel] 755—ab
incidence, inverse relation between iodin in food and drink and, [McClendon & Hathaway] *1668
incidence, iodin deficiency and prevalence of simple goiter in Michigan, [Olin] *1328
GOITER, morbidity of endemic goiter, [Collier] *1475
mortality in operations for, [de Quervain] 752—ab
of adolescents, [Gold & Orator] 1659—ab
origin of, [Goldemberg] 427—ab
prevention of, in pregnant, 1045—ab
spontaneous hemorrhage in, [Schwoerer] 1739—ab
surgery, negligence imputable to operating surgeons, 2143—Ml
thymic hyperplasia in, [Giordano] 157—ab
Toxic: See Hyperthyroidism
treatment with rest, [Chaffin] 658—ab
treatment of, 1592—ab
treatment, ovarian treatment of goiter, [Coulaud] 584—ab
treatment with iodin, [Jagic & Spengler] 931—ab
GONADS: See also Ovary; Testes
GONADS and spleen, relations between, [Giunta] 1085—ab
GONOCOCCI, resistance of, [Lorentz] 1089—ab
GONOCOCCUS VACCINE, 967
GONORRHEA, [Stümpke] 666—ab
acute, vaccine treatment of, [Duhot] 1823—ab
agglutination in gonococcus infection with concentrated serum, [Herrold] *964
chronic, mercurochrome—200 soluble intravenously in chronic gonorrhea and its complications, report of 10 cases treated at Ohio State Penitentiary, [Whitman] *1914
in women, [Naujoks] 1827—ab
in women, gonorrheal complement fixation test in, [Barringer & Van Bose] 580—ab
in women, tests for cure of, [Abraham] 1229—ab
in women, vaccine therapy in, [Kraul] 344—ab
treatment, acriflavine intravenously in, [Jacob & Verasingam] 1151—ab
treatment, vaccine therapy and milk injections in, [Tansard] 1737—ab
when is it cured? 148, 412, 569, 649
GOTTSTEIN, retirement of, 1459
GOUT, blood dilution in, [Laporte & Rouzard] 925—ab
structure of gouty tophi, [Chauffard & Wolf] 340—ab
GRANULOMA, coccidioidal, [Davis] 1890—ab
GRAPEFRUIT, vitamin content of, [Morgan & Chaney] 1889—ab
GRAVES' DISEASE: See Goiter, exophthalmic
GREENLAND'S importance for scientific research, [Bay-Schmith] 1090—ab
GROWTH: See also Tissue cultivation; Trephones
GROWTH and environment, [Degkwitz & others] 1008—ab
and light, 797—E
as factor in prognosis: "outgrowing" disease, [Holt] *1333
of arm and respiration, [Godin] 1481—ab
GUANIDINE intoxication, tetany not due to, [Greenwald] 1816—ab
GUARDIANSHIP of infants bill, 1456
GUEMES, tribute to, 1210
GUINEA-PIGS, tuberculosis in, [Kleinschmidt] 70—ab
GUMMAS at sites of injections, [Gougert] 247—ab
GYNECOLOGY, diathermy in, [Lindemann] 588—ab
intermittent aspiratory hyperemia in, [Bradley] 1144—ab
local anesthesia in, [Polgár] 1660—ab
rectal palpation in, [Daels] 1005—ab
relation of backache to, [Graves] 497—ab
treatment in, present tendencies of, [Liepmann] 1740—ab
GYNECOMAZIA: See under Breast; Hermaphrodism

H

HAARLEM OIL, death after, [Walcher] 931—ab
HAIR, action of skin and hair extracts on growth of, [Sivori & Rebaudi] 165—ab
color of, [Mayr] 2000—ab
excessive, cosmetic depilation, [Nobl] 1575—ab
Schridde's cancer hairs, [Friedrich] 170—ab
HALLUCINATIONS, [Bleuler] 663—ab
chronic hallucinatory psychoses, [Claude] 1655—ab
HAND, artificial, movable, [Platou] 589—ab
contamination, possible source of, [Ramaley] 1461—C, 1802
HARE LIP and cleft palate, [Baird] 1390—ab
HARRISON ACT, guarding against violation of, [Blackmar & Woolley] 1984—C
HAY-FEVER, botany of southwest Texas, with reference to, [Kahn] *871
autumnal, immunologic observations in, [Bernton] *1434, [Scheppegrell] 1714—C
botanic survey of Kansas City, Mo., and neighboring rural districts, with reference to flora responsible for, [Duke & Durham] *939
electric fan in seasonal treatment of, [Kahn] 1883—C
nonseasonal, [Davison] 1812—ab

HAY-FEVER, physical factors pertaining to; amount of seasonal precipitation, [Gould] *893
pollen density, aeroplane tests of, [Schepegrell] 1079—ab
HEAD injury, nervous and mental diseases following, [Hoag] 1468—ab
injuries, pressure of spinal fluid significant in, [Thorning & Lapat] 1650—ab
injuries, surgical aspect of headache following, [Carpenter] 1650—ab
injury, subdural fluid accumulations following, [Naffziger] *1751, [Reynolds] 2069—C
HEADACHE, lumbar puncture, raising spinal fluid pressure, with especial regard to effect on, [Solomon] *1512
traumatic, cause of, [Trotter] 2147—ab
HEALTH: See also Schools
HEALTH, Board of Health versus Board of Education as to requiring vaccination, 1069—MI
center, 1718
education, contribution physicians have to offer to, [Faber] 4.3—ME
education, nutrition work as basis for, [Horwood] 1077—ab
examinations, education of public as to value of, [Bryant] 976—ab
examinations, periodic, 1135
examinations, periodic, education of medical students for, [Schmitt] 976—ab
Insurance: See Insurance, health
international health work, 1560
officers, foreign, 728
officers, foreign, visit of, 1707
posters, Hygeia—prize contest for, 1786
public, and lottery, 1377
public, Belgian superior council of, 1625
public exhibition, 1377
public health diplomas, new regulations for, 313
public health nursing, census of, 1276
public, high standard for Dr. P.H. degree, 4—ab
public, International Bureau of, [Phipson] 245—ab
public, organization of, 1375
Public Health Service physicians to Veterans' Bureau, 2060
public health summer schools, 804, 1791
public health work, 1134
public, present organization of public health service of Greater Berlin, 1878
rural, extent of rural health service, 1873
state-wide health association, [Richardson] 1810—ab
HEARING, apparatus for, [Fassl] 72—ab
HEART, acceleration in absence of inhibitory center, [Tulgan] 1391—ab
after acute infections, [Hamburger & Priest] 58—ab
anomalies, cardiac infantilism and endocrines, [Bickel & others] 1656—ab
anomalies, congenital mitral stenosis, with other developmental defects, [Donnally] *1318
anomalies, rare, congenital, [Willock] 583—ab
artificial, [Hauffe] 1999—ab
Auricular fibrillation: See Auricular Fibrillation
beat, apex tracing of, [Mougeot] 162—ab
beat, determination of variations in ventricular systole, [Bartos & Burstein] 921—ab
block, acute cardiac failure with right bundle block, [Horsfall] 1820—ab
block, complete, [Leconte] 1821—ab
block, complete auriculoventricular [Prusik] 1235—ab
block, congenital, [Romberg & White] 1476—ab
block, experimental, in chick embryo, [Johnstone] 1395—ab
block, many cardiac mechanisms in, [Fenn] 921—ab
block, neurogenous Adams-Stokes' syndrome, [Kahler] 589—ab
block, recurrent complete, [Carter & Dieualde] 334—ab
block with unusual signs, [Pinchin & Gloyne] 751—ab
bundle of His, [Rossello & Rodriguez] 753—ab
calcification of ventricle wall causes epilepsy, [Taft] 240—ab
chemical regulation of, [Asher] 343—ab
congenital affections of, [Lemaire & Blechmann] 1004—ab
dextrocardia, [Jones] 924—ab
disease, drugs in treatment of, [Lewin] 506—ab
disease, effect of massive doses of digitalis, [Lauten] 1077—ab
disease, exercise cardiac functional test in 100 cases of, [Propst] *2102
disease in children, rheumatic, [Denzer] *1243
disease, incidence of, in negro, [Woody] 1149—ab
disease, management of, in children, [Barbee] 1471—ab
disease, myoma and heart, [Winter] 1405—ab
disease, prevention of, 217, [Witt] 1472—ab
HEART disease, quinidin in, [Pardee] 1149—ab
disease, recurring cardiac infections in children, [Smith & Stulik] 239—ab
disease, rheumatic carditis, [Raven] 338—ab
disease, subdiaphragmatic pain of cardiac origin, [Billings] 156—ab
disease, treatment of, [Jagic] 169—ab
disturbances of, associated with diseases of thyroid gland, [Wilson] *1754
effect of acetylsalicylic acid on, [Mendenhall & Camp] 1078—ab
efficiency of, [Meakins] 1820—ab
electrocardiogram of ventricular enlargement, [White] 1722—ab
electrocardiogram, value of, in diagnosis and treatment of heart disease, [Wilson] 1722—ab
electrocardiogram in diagnosis and prognosis of coronary artery disease, [Oppenheimer & Rothschild] 1722—ab
electrocardiogram in diagnosis of adhesive mediastinitis, [Carter & Dieualde] 2077—ab
electrocardiography, electric axis of, [Bosco] 166—ab
embryology of, [Backman] 1904—ab
enlarged, palpation in diagnosis of, [Bard] 1004—ab
epinephrin injection into, [Lenormant & others] 1304—ab
first to last to die of all elements in, [Pick] 1825—ab
function and sugar, 1610—E
function, estimation of, in sports, [Libenský] 1094—ab
gangrene of foot in infant caused by cardiac lesion, [Hoopman] 1897—ab.
humoral transmission of nervous impulses, [Loewi] 72—ab, 1826—ab, [Duschl] 73—ab, [Hohenkamp] 165—ab
hypertrophy, compensatory, [van Leersum] 253—ab
hypertrophy of, idiopathic, in infant, [Carrington & Krumbhaar] 2079—ab
in arthritis deformans, [Boas & Rifkin] *1596
in hypertension, [O'Hare & Walker] 1815—ab
in pregnancy, [Schmidt] 588—ab, [Daly] *1439
in running races, [Rautmann] 757—ab
insufficiency, hypertension in, [Loschkarewa] 1087—ab
insufficiency, myocardial, peripheral stasis in, [Boas & Boonefef] 1729—ab
insufficiency, some phases of, [Coleman] 1812—ab
massage of, in syncope, [Levy] 1994—ab
motion pictures of, [Zezschwitz] 2093—ab
murmurs from exertion, [Bonnin] 1736—ab
murmurs, functional, [Kovářicek] 1488—ab
murmurs in heart disease, [Stubbs] 1650—ab
murmurs, true and false presystolic murmurs, [Reid] *1040
muscle, estimating, [von Phul] 1397—ab
muscle activity and oxygen consumption, [Fenn] 661—ab
nerves of, and asthma, [Frey] 2093—ab
size of normal heart, [Fossier] *2016
small, [Meyer] 167—ab
surgery, experimental, [Levine & others] 2077—ab
surgery, intracardiac surgery, [Allen] 823—ab
suture of, [Smith] 576—ab
suture of, ligating interventricular branch of left coronary artery and vein, [Davenport] *1840
syphilis of, [Howard] 1143—ab, [Jacobæus] 1406—ab
thrill, true and false presystolic thrills, [Kahn] *1781
tracings, interpretation of impulses over left auricle, [Dana] 820—ab
valves, severe valvular lesion and cirrhosis of liver in child, [O'Donnell] 1480—ab
Ventricular fibrillation: See Ventricular Fibrillation
HEARTBURN, 1202—E, [Levin] 1227—ab
HEAT, effect of working in, not accidental, 1222—MI
moist and dry, effect of, on blood, [Lozinsky] 496—ab
production, relation of thalamus to, [Rogers & Lackey] 155—ab
regulation and water exchange, 1200—E
regulation of, [Plaut] 1484—ab
HEIGHT-WEIGHT-AGE TABLES, abuse of, as indexes of health and nutrition, [Baldwin] *1
HELIOTHERAPY: See also under Joints, tuberculosis; Larynx; Tuberculosis; etc.
HELIOTHERAPY, behavior of blood vessels in wounds exposed to sunlight, [Torraca] 1482—ab
dangers of, [Stephani & Stephani] 1153—ab
of larynx, [Samengo] 167—ab
sun baths for school children, 1794
HELMINTHIASIS, operations for, [Dieckmann] 1739—ab
specific antibodies in, [Isbecque] 1573—ab
HEMANGIOMA: See Angioma
HEMATOMA of thigh, [Dearth] 746—ab
spontaneous, of abdominal wall, [Renner] 1309—ab
spontaneous perirenal hematoma, [Roth] 998—ab
HEMATOPORPHYRIN, influence of, on rickets in rats, [van Leersum] 254—ab
HEMATURIA, cause of, [MacKenzie] 746—ab
in appendicitis, [Gottlieb] 1405—ab
HEMIANOPIA in untreated secondary syphilis, [Sichel & Fraser] 241—ab
restitution after brain lesions, [Goldstein] 663—ab
HEMIPLEGIA, motor spasms in, [Dimitri] 1656—ab
HEMOCHROMATOSIS, [Dunphy] 1297—ab
HEMOCLASTIC CRISIS, alimentary leukocytosis, [Feinblatt] 1076—ab
and liver function in puerperium, [Rivière & Valle] 1231—ab
and the pneumogastric, [Kmietowicz & Koskowski] 1152—ab
in typhoid, [Barrow & Franklin] 334—ab
influence of lymph in, [Kmietowicz & Koskowski] 1822—ab
nervous shock, [Simon & Fontaine] 67—ab
HEMOGLOBIN: See also Erythrocytes
HEMOGLOBIN, antigenic properties of, [Heidelberger & Landsteiner] 61—ab
determination, new methods of blood analysis, [Wu] 751—ab
HEMOGLOBINURIA, paroxysmal, and autolysins, [Lüdke] 829—ab
HEMOLYSIS by bile and in general, [Joannidès] 1090—ab
relationship of hemolytic disorders to pernicious anemia, [Panton & others] 1302—ab
HEMOPHILIA, [Feissly] 423—ab, 662—ab
blood platelets in, [Feissly & Fried] 2092—ab
does hemophilia exist in woman? [Bauer & Wehefritz] 1738—ab
in negro, [Taylor] 420—ab
splenectomy in hemorrhagic diathesis, [Wild] 1741—ab, (correction) 2000—ab
with male heredity, [Vesely] 346—ab
HEMOPLASTIN, fatal anaphylaxis following, [DeLee] 1564—C
HEMOPTYSIS: See also Lung Hemorrhage
HEMOPTYSIS and dilatation of bronchi, [Bezançon & others] 1153—ab
and vagosympathetic tonus, [De Martini] 1823—ab
misrepresentations about having spit blood and having had influenza, 494—MI
relation of blood pressure to, [Walker] 1003—ab
HEMORRHAGE from compression of trunk, [Kunz] 1742—ab
cardiovascular reactions to hemorrhage and transfusion, 1866—E
internal, spontaneous perirenal hematoma, [Roth] 998—ab
intra-abdominal, [Prat] 426—ab
pathogenesis of, [Roskam] 249—ab
postpartum, mucous polyp of uterus causes, [Nyulasy] 924—ab
treatment, hemostasis with sodium citrate, [Renaud & Jugz] 1303—ab
uteroplacental, [Nubiola] 662—ab
HEMORRHAGIC DIATHESIS: See Hemophilia
HEMORRHOIDS, treatment of, 406
HEMOTHERAPY, autohemotherapy in dermatology, [Schulmann] 1742—ab
protein therapy with hemolyzed own blood, [Brünner & Breuer] 1742—ab
treatment with own blood, [Vorschütz & Tenckhoff] 1087—ab, 1746—ab
HEREDITY, alcohol and germ plasm, 1444—E and obesity, 470—E
and syphilis of the nervous system, [Husler] 1234—ab
atavism in hereditary hemorrhagic telangiectasia, [Fitz-Hugh] 495—ab
germinal pathology, [Vignes] 1402—ab
in hypertension, [O'Hare] 1888—ab
in study of causes of disease, [Meulengracht] 590—ab
influence of maternal hormones on mental and physical development, [Blouw] 1406—ab
lecture on hereditary transmission, 1709
modification of germ plasm, 211—E
morbid, and prenatal pathology, [Vignes] 1304—ab
Morgan theory of, [Bonnier] 1828—ab
of eye abnormality caused by roentgen ray, [Bagg & Little] 1570—ab
of vegetative syndromes, [Ullmann] 1825—ab
periodic familial cancer, [Swoboda] 1309—ab
potential characters in fowls, [Pézard & others] 1653—ab
sex-linked, in fowls, [Pézard & Caridroit] 1898—ab
d'HERELLE'S PHENOMENA: See Bacteriophage
HERMAPHRODISM, experimental, [Krause] 70—ab
HERNIA, congenital, of uterine adnexa, [Lussana] 1305—ab
diagnosis, pneumoperitoneum as aid in, [Farr] *1774
diaphragmatic, [Fineman & Conner] 1991—ab
diaphragmatic, recurring, [Truesdale] 2080—ab
duodenal, a congenital anomaly, [Andrews] 499—ab
femoral, surgical anatomy of, [Souttar] 1228—ab
inflammation in hernial sacs, [Smith] 1145—ab
inguinal, paraffinoma of vas deferens as unusual complication of, [Watson] *1935

HERNIA, irreducible, hernia obstructed by mesenteric glands, [Reinhold] 581—ab
paraduodenal, right, recovery after operation (third in medical literature), [Novak & Sussman] *1664
sciatic, of Meckel's diverticulum, [Brodnax] *440
strangulated sliding, [Smith] *963
through foramen of Winslow, [Douglas] *1607
through gap in transverse mesocolon, [Lombard] 502—ab
umbilical, hernlotomy for, [Vallack] 1820—ab
umbilical, prolapse of intestine through patent omphalomesenteric duct, [Cutler] 2081—ab
ventral, congenital bilateral, [Leo-Wolf] *2030
HERNIOTOMY from within, [Laroque] 236—ab
in difficult hernias, [Tinker & Sutton] 1644—ab
inguinal, aponeurosis of external oblique as source of living sutures for, [Adair] *629, [Adair] 911—C, [Shephard] 911—C
living suture for, [McEachern] 2080—ab
myoplastic, for double hernia, [Tzaico] 1899—ab
pulmonary complications after, [Hubbard] 1394—ab
reflex atrophy and contracture of penis following, [Wilson] *1667
HEROIN, interdict manufacture of, [Hubbard] 749—ab
legislation on, [Hare & others] 1631—C
Ways and Means Committee reports favorably on heroin bill, 1207
HERPES, demonstrating herpetic lesions of central nervous system, [McClellan & Goodpasture] 748—ab
corneal, from ovarian disturbance, [Niedermeyer] 2091—ab
experimental production of herpetic lesions, [Goodpasture & Teague] 747—ab, 1040—E
experimental recurring herpes, [Nicolau & Banciu] 926—ab
herpetic meningitis, [Philibert] 503—ab
modern conception of, [Béthoux] 424—ab
pregnancy herpes, [Dexeus Font & Serra Rabert] 1306—ab
virus of encephalitis and, [Bastai & Busacca] 830—ab, [Parker] 2083—ab
virus in blood, [Bastai & Busacca] 1308—ab
virus, pathway of herpes febrilis virus into central nervous system, [Goodpasture & Teague] 747—ab
virus, survival of, in vitro, [McCartney] 1648—ab
ZOSTER, [Achard] 1231—ab
zoster, an infectious disease, [Cookson] 1897—ab
Zoster and Varicella: See Chickenpox
zoster, antigens and antibodies in, [Netter & others] 926—ab
zoster, bilateral, [Walker] 1735—ab
zoster, experimental, [Teague & Goodpasture] 748—ab
zoster, further research on, 1614—E
zoster with motor paralysis, [Bloedorn & Roberts] *622, [Juergens] *1342
HICCUP, epidemic, specificity of streptococci in etiology of diseases of nervous system, [Rosenow] *449
incessant, [Stratigopoulos & Psaraftis] 585—ab
of long duration, [Guillain & others] 926—ab
postencephalitic myoclonia of diaphragm, [Halbron & Gamblliard] 1152—ab
simple treatment of, [Hishikawa] 1738—ab
HIP JOINT, arthritis deformans of, [Calot] 1230—ab
disease, nontuberculous, in young, [Fruelich] 67—ab
dislocation of, congenital, [Schanz] 252—ab, [Soutter & Lovett] *171, [Dickson] 1816—ab
dislocation of, congenital spontaneous recovery of, [Slomann] 920—ab
osteochondromatosis of, [Henderson] 1649—ab
surgery, new ligaments for, [de Frenelle] 2087—ab
HISTAMIN in causation of asthma, [Ramirez & St. George] 657—ab
HOCHENEGG'S attack on profession; verdict of disciplinary court, 2063
HODGKIN'S DISEASE: See Lymphogranuloma
HOOKWORM DISEASE: See Uncinariasis
HORMONES: See under Endocrines
HOSPITAL LIBRARY AND SERVICE BUREAU of American Conference on Hospital Service, annual report of, [Hamlin] 975—ab
HOSPITALS, a public necessity in modern life, 1566—MI
and labor party, 1704
annual congress on medical education, medical licensure, public health and hospitals, 307—E, 798, 890, 972
charitable corporations—act of orderly in hospital, 2143—MI
charitable, not liable to strangers, 996—MI
costs, [Whitg] 409—C
costs, past and present, [Smith] *110
efficiency of, factors that indicate, [Codman] 974—ab, [MacEachern] 974—ab
HOSPITALS, efficiency, necropsy percentage in relation to, [Hektoen] *949
fees and private patients, 1708
in restricted residential neighborhood, 416—MI
injured employee contracting typhoid in, 1294—MI
Interns: See under Interns
military, expenditures for, 807
Norwegian, [Welch] 1217—C
private, as public agencies; right of hospital to exclude physicians generally from use of hospital accommodations denied, 1805
roentgen-ray service in, fundamental requirements of, [Case] *2071
service in United States, 149
service in United States; third presentation of hospital data by Council on Medical Education and Hospitals of the American Medical Association, *118
working day in, 1212
HOWARD UNIVERSITY, 312
HUMERUS, fracture of upper end of, [Worcester] 1469—ab
fractures through lower epiphysis of, occurring in children, [Eikenbary] *78
supracondylar fractures of, dressing for, [Eliason] *1934
HUMIDITY, and high temperature, effects of, 1719
HUNGER pains, clinical significance of, [Higgins] 899
effect of, on gastric secretion, [Kunde] 1889—ab
HYDATID CYSTS: See Echinococcosis; and under names of organs
HYDNOCARPUS and chaulmoogra oils, comparative value of ethyl esters of, [Read] 1082—ab
HYDRAMNION, life expectancy with, [Poeck] 169—ab
HYDRARGYROSIS, intermittent, evidence of anaphylactic character of, [Miller & Lewin] *1177
HYDROCEPHALUS of mechanical origin, [Rivarola] 426—ab
puncture of lateral ventricle for, [Rueda] 1484—ab
spina bifida with, [Grigsby] 419—ab
surgical treatment of, [Koljubakin] 1086—ab
HYDROGEN ION CONCENTRATION, film method for determining reaction of liquids, [Buckmaster] 421—ab
Sørensen unit for, 227
HYDROLOGY, promotion of teaching of, 642
Medical Second Spanish Congress on, 1877
HYDRONEPHROSIS, intermittent, [Hailes] 338—ab
partial, [Stoppato] 827—ab
rupture of kidney in, [Reschke] 2092—ab
HYDROPERICARDIUM, concurrent, and pneumothorax, [Fox] *467
HYDROPHOBIA: See Rabies
HYGIENE: See also Health
HYGIENE, instruction in, 1374
radio talks on, 1797
HYMENOLEPIS diminuta, infestation with, (rat tapeworm), [Butka] *875
nana, treatment of infestation with, 1382
HYPERESTHESIA in acute abdominal diseases, [Cecil] 932—ab
HYPERGLYCEMIA: See Blood sugar
HYPERNEPHROMA of ovary in child, [Downes & Knox] *1315
secondary, in femur, [Broster] 63—ab
spinal metastases of, [Buschmann] 498—ab
HYPERSENSITIVENESS: See also Anaphylaxis
HYPERSENSITIVENESS, specific, triple reaction due to, [Hooker] 243—ab
HYPERTENSION: See Blood Pressure, high
HYPERTHYROIDISM: See also Goiter; Thyroid
HYPERTHYROIDISM and influenza, [Marañón] 1403—ab
differential blood count in, [Hutton] 1647—ab
effect of subtotal thyroidectomy in toxic goiter, [Segall & Means] 822—ab
heart in, [Dameshek] 1297—ab
iodin therapy in toxic goiter, [Mason] 1725—ab
Kottmän's test for, 1802
latent, diagnosis of, [Escudero] 754—ab
liver injury in thyrotoxicosis, [Warfield & Youman] 1809—ab
masked as heart disease, [Levine & Sturgis] 919—ab
when roentgenotherapy is not indicated in treatment of, [McKinney] 658—ab
HYPERTROPHY, congenital total hemihypertrophy, [Lisser] *1046
HYPNOSIS in gynecology, [Dick] 1085—ab
in therapeutics, [Koster] 668—ab
HYPNOSIS-CATHARSIS in certain mental affections, [Breukink] 1236—ab
HYPOTHALAMUS and glycemia curve, [Vaný-sek] 2094—ab
HYPOTHETIC QUESTION, roentgenographic examination for prisoner, 330—MI
HYPOTHYROIDISM, arteriosclerosis in thyroid deficiency, [Fishberg] *463
Insufficiency of thyroid-sexual system, [Borchardt] 588—ab
without myxedema, [Lawrence] 1077—ab
HYSTERECTOMY, supravaginal, [Shaw] 1652—ab
abdominal, in puerperal infection, [Auvray] 1996—ab
HYSTERIA, epileptic or hysteric seizure? [Chavigny] 927—ab
shortcomings from, not "cruel treatment," 233—MI

I

ICHTHALBIN, 565—P
ICHTHYOL, 565—P
ICTERUS: See Jaundice
IDIOCY, amaurotic family idiocy, [Duarte Salcedo] 753—ab
Mongolian, not form of congenital syphilis, [Riddel & Stewart] 582—ab
mongolism in successive members of same family, [Glassburg] *1196
ILEOCECAL VALVE, incompetence of, [Jones] 59—ab
ILETIN (Insulin-Lilly), U—40; 1443
ILEUS: See Intestines, Obstruction
ILIUM, fracture of anterior superior spine of, [Carp] 1645—ab
IMIDAZOLES, excretion of, in urine, [Koessler & Hanke] 1892—ab
IMMUNITY and cell function, [Oeller] 167—ab and colloids, [Pacheco] 1822—ab
as reflex, [Reitler] 1309—ab
by fertilization, [Bier] 1903—ab
immunizing function of subepithelial lymph glands, [Digby] 65—ab
influence of suprarenals on resistance, [Scott] 1396—ab
local, and cutaneous infection, [Combiesco] 1653—ab
nonspecific, 1465
radiation and bactericidal power of blood, 2123—E
IMMUNIZATION, local, [Delater] 502—ab
therapeutic, [Crofton] 1301—ab
IMPETIGO contagiosa, [Smith & Burky] 1395—ab
INCISION, abdominal, for lesions in upper zone, [Southam] 1479—ab
abdominal, for pelvic conditions, [Fothergill] 1479—ab
new, for clavicle operations, [Soutter] *1179
INCOME TAX: See under Taxation
INDIA, census of, 983
INDIAN MEDICAL SERVICE, allowance for quarters in, 1454
proposed abolition of, 2130
salaries in, 901, 2060
Secretary Work comments on, 983
INDIANS, American, Maya Medical laws to be translated, 1272
INDICANURIA as guide in treatment with albumin milk, [Paul] 1308—ab
frequency of, [Gordon] 421—ab
INDIGESTION: See Dyspepsia
INDUSTRIAL accidents, plans to reduce, 312
accidents, prevention of, 1133
diseases, notification of, 1981
hygiene, factory medical inspection, 2131
INDUSTRY, detrimental effect of monotony in, 643
medical supervision in, 887—E
psychology of, 1208
INFANT asylums, dangers of, [Labbé] 1401—ab
care of; postnatal clinics, [Carr & Ratner] 819—ab
colloidal stability of serum in, [Nassau & Heudelsohn] 72—ab
daily variations of weights and temperature in, [Putzig & Vollmer] 1487—ab
feeding, acidified milk with karo syrup for, [Mulherin] 1811—ab
feeding, breast nursing in puerperal affections, [Runge & Lauer] 2091—ab
feeding, complemental feeding of new-born, 305—E
feeding, concentrated albumin in, [Eckert] 1008—ab
feeding, dangers of underfeeding, [Exchaquet] 503—ab
feeding, gastric problems in infancy, 472—E
feeding, hydrochloric acid milk in, [Faber] 239—ab
feeding, increased prevalence of breast feeding, [Schlossmann & others] 665—ab
feeding, indicanuria as guide in treatment with albumin milk, [Paul] 1308—ab
feeding, infant mortality in relation to breast feeding, [McKay] 1397—ab
feeding, mixed diet in, [Jundell] 1158—ab
feeding, nursing by syphilitic mothers, [Hesse] 2093—ab
feeding, sterilized human milk in, [Reber] 1232—ab
feeding, modified breast milk, [Funkhouser] 1811—ab
feeding, soup from calf bone-marrow in, [Wiltschke] 342—ab
feeding, use of acidified milk in, 1066
feeding, value of milk acidified with lemon juice; its combination with egg yolk to add the antirachitic factor, [Hess & Matzner] *1604
feeding without milk, [Hamburger] 829—ab
food and electric excitability of, [Ockel] 342—ab

INFANT, incidence of disease in, [Curtis & Taylor] 239—ab
Mortality: See also Vital Statistics
mortality at Bogota, [Enciso] 1484—ab
mortality, crusade against, 1456
mortality in Argentina, [Acuña] 754—ab, 1210
mortality in relation to breast feeding, [McKay] 1397—ab
mortality in Tunis, [Dinguizli] 502—ab
mortality since war, [Feller] 253—ab
New-born: See also Melena
new-born, blood pressure in, [Rucker & Connell] 575—ab
new-born, injuries to child at birth, [Stern & Schwartz] 2149—ab
new-born, intracranial birth hemorrhages, 395—E, [Eblen] 1471—ab, [Saenger] 1485—ab
new-born, iron in blood of, [Gallo] 2089—ab
new-born, leukocyte count and digestion, [Hainisz & Heller] 1308—ab
new-born, rate of sugar absorption in, [Flood] *1595
new-born, suprarenal hemorrhage in, [Corcoran & Strauss] *626
nutrition, wasting disorders of early infancy, [Parsons] 1652—ab, 1820—ab
nutrition disturbances of, [Reyher] 930—ab
nutrition disturbances of, classification of, [Schweizer] 341—ab
posture reflexes in, [Magni] 1823—ab
premature, fate of, [Brandt] 506—ab
premature births, influence of syphilis on, [Baumm] 429—ab
premature, sense reactions in, [Peiper] 1307—ab
vomiting in, habitual, [Berro] 2089—ab
weight of, statistics on, [Klotz] 1740—ab
INFECTION, focal, [Rhodes] 236—ab
focal, and mental disease, [Kopeloff & Kirby] 417—ab
focal, chronic, rectum source of, [Fansler] 1006—ab
focal, gastric ulcer and arthritis, [Nakamura] 821—ab
focal, physicians, dentists and focal infection in the Dakotas, [Morsman] *1759
local, treatment of, by intravenous injections of mercurochrome—220 soluble and of gentian violet, [Young & Hill] *669
surgical, neo-arsphenamin in, [Birt] 757—ab
INFECTIOUS DISEASE, control of epidemics, 1447—E
in Holland, law regarding, 2134
in South America, [Kraus] 1308—ab
increase of, criticism of younger practitioners, 1797
heart following acute infections, [Hamburger & Priest] 59—ab
prophylaxis of, of children, [Hutinel] 249—ab
radiotherapy in, [Ceresole] 1005—ab
symptoms of appendicitis in, [Vysín] 1310—ab
INFLAMMATION, physical pathology of, [Schade] 756—ab
INFLUENZA and hyperthyroidism, [Marañón] 1403—ab
agglutinins for Pfeiffer bacillus in influenza and measles serum, [Sharp & Jordan] 1148—ab
bacillus: See Bacillus, Pfeiffer's
epidemic, 902
epidemics, in children, [Levy] 1079—ab
in infants, [Nassau] 829—ab
in Paris, 644
misrepresentations about having spit blood and having had influenza, 494—MI
INJECTIONS, infected ampules, [Knauer] 830—ab
intra-arterial, of sodium iodid, [Brooks] *1016
intracutaneous therapy, [Léval] 1308—ab
intradermal salt solution test, value in "nephritis" with generalized edema, [Aldrich & McClure] *1425
intraperitoneal, dialysis of blood in living subjects, [Ganter] 345—ab
intratracheal medication, [Martin Carrasco] 167—ab
intravenous, continuous intravenous drip, [Matas] 2080—ab
intravenous, effect of boiling solutions, 1067
intravenous saline solution, effect of, on leukocyte count, [Bluemel & Lewis] 997—ab
intravenous, intra-ocular pressure as molecular concentration of blood is modified, [Weekers] 585—ab
intravenous, venous hardening after, 739
painless puncture for, [Fernández] 69—ab
reflex or immunity reaction? [Schubert] 505—ab
subcutaneous pseudotumors from injection of drugs, [Nicod] 1084—ab
INJURIES, treatment of, during acute stage by diathermy, [Holmblad] *1856
INKS, medicolegal identification of, 318
INSANE, care of, behavior of families of psychopaths in respect to physician and patient, [Vinchon] 1231—ab
INSANE, criminal responsibility of, 1621, 2061
menace to society of allowing insane their liberty, 1877
shock therapy in, [Pascal] 1304—ab
INSANITY: See also Psychiatry
INSANITY and art, [Vinchon] 1152—ab
and goiter, [Foss & Jackson] 1992—ab
autosynnoia, [Heveroch] 1660—ab
award of damages against physicians for wrongful detention as lunatic, 1057
blood ferments in psychiatry, [Kafka & Hlava] 346—ab
commission on lunacy administration, 1560
confusional paranoia, [Heveroch] 346—ab
differentiation of manic depressive psychosis and catatonia, [Saussure] 1152—ab
hypnosis-catharsis in treatment of certain mental affections, [Breukink] 1236—ab
infectious psychosis, [Farani & Fajardo da Silveira] 928—ab
limited effect of order of board of, 1720—MI
mental sufficiency for transaction of business definitions, 1466—MI
physiological conditions in, [Ludlum] 1297—ab
postoperative, [Cokkinis] 1229—ab
psychopathology of "normal" families, [Boven] 1084—ab
INSECT metamorphosis and autolysis, [Bishop] 578—ab
INSOMNIA: See Sleep, disturbances
INSTITUTE of colonial medicine, 316
of Sanitary Technic, foundation of, in Paris, 47
INSTRUMENT makers, plight of American makers, [Keen] 147—C
dermotome, [Hagen] *1933
visceral retainer, [Farr] *1199
INSULIN, [Desgrez & others] 164—ab, [Brugsch] 665—ab
absorption of, from scrotal sac, [Fisher] 332—ab
abscess from, [Friedlaender] 1904—ab
action of, [Krogh] 70—ab, [Bickel & Collazo] 251—ab, [Bissinger & others] 428—ab, [Buchner & Grafe] 428—ab, [Laufberger] 1007—ab, [Collazo & others] 1088—ab, [Bornstein] 1826—ab
action of alcohol solution of, [Harrison] 500—ab
action of alkalies on, [Witzemann & Livshis] 578—ab
action of, and cholesterolemia, [Nitzescu & others] 1401—ab
action of, and metabolism, [Gabbe] 1741—ab
action on blood ions, [Staub & others] 505—ab
action, blood sugar during, [Cori & others] 656—ab, [Lawrence] 1479—ab
action of, extrahepatic, [Frank & others] 1740—ab
action of, dissociated action of, on glycosuria and acetonuria, [Widal & others] 1402—ab
action, does insulin increase tolerance? [Newburgh] 1146—ab
action of foreign proteins after, [Sefcík] 1310—ab
action of garlic and, [Mahler & Pasterny] 1485—ab
action of, in phlorizinized animals, [Cori] 1477—ab
action of, on behavior of kidneys in respect to glucose, [van Creveld & van Dam] 170—ab
action of, on different species of animals, [Houssay & others] 69—ab
action of, on glycogen formation, [Babkin] 500—ab
action of, on glycosuria and on acidosis, [Labbé] 1899—ab
action on hyperglycemia and metabolism, [Arnovljévitch & Schmidt] 1654—ab
action of, on milk, [Giusti & Rietti] 1083—ab
action of, on phlorhizin diabetes, [Ringer] 578—ab
action of; pancreas hormone and utilization of sugar, [Werthelmer] 2095—ab
action on reducing substance in spinal fluid, [Kasahara & Uetani] 1816—ab
action on sugar production, [Issekutz] 1007—ab
action of, theory of, [Brugsch] 1825—ab
action of, on thyroidectomized rabbits, [Duchenau] 1083—ab
action of, on tissue cultures, [Gey & Thalhimer] 1609
action of trypsin on, [Epstein & Rosenthal] 1990—ab
action of various drugs on, [Maganta & Biascotti] 754—ab
actns of, physiologic, [Geelmuyden] 1828—ab
administration, [Murphy] *1264
administration by mouth, [Salén] 932—ab
administration of sugar with, [de Jongh & Laqueur] 1236—ab
and decomposition of sugar, [Neuberg & others] 251—ab
and exophthalmic goiter, 1877
and ketosis, 1695—E
INSULIN and liberation of heat, [Noyons & others] 1230—ab
and pierotoxin hyperglycemia, [Kogan] 2091—ab
and proteidic sugar, [Bierry & others] 826—ab
and rigor mortis, [Baur & others] 1089—ab
by-effects of, [Fischler] 344—ab
convulsions from, blood phosphate after, [Winter & Smith] 1301—ab
cooperative buying as applied to, 1458
death due to, 1560
does not affect Wassermann reaction, [Kretschmer] 1731—ab
dosage of, [Desgrez & others] 1996—ab
doses, timing of, [Allen] 1937—ab
dual nature of, [Ambard & others] 1654—ab
excretion of, from kidneys, [Fisher & Noble] 332—ab
experiments on, [Delezenne & others] 163—ab
German, [Zuelzer] 252—ab
glucose equivalent of, [Allan] 495—ab
hypoglycemia from, and anhydremia, 1269—E
in blood, 1782—E
in Diabetes Mellitus: See Diabetes Mellitus
in exophthalmic goiter, [Lépine & Parturier] 1152—ab
in Hungary, 405
in pancreas of domestic animals, [Venge & Wilson] 1225—ab
in tissues other than pancreas, 1521—E, [Best & others] 1889—ab
insulin commission in Buenos Aires, 1060
insulin commission of Brazil, 140
insulin-like substance in gastric mucosa, [Ivy & Fisher] 997—ab
insulin-like substances in kidney, spleen and muscles, [Ashby] 332—ab
interference of some substances with, [Magenta & Biasotti] 1083—ab
inunction treatment with, [Wallgren] 756—ab
local anaphylaxis following injection of, [Sturtevant] *964
muscles after insulin and fasting, [Kuhn & Baur] 1999—ab
nutrition and action of, [Abderhalden & Wertheimer] 1826—ab
pancreatectomized dogs kept alive with, [Fisher] 998—ab
percutaneous insulin treatment, [Wallgren] 590—ab
perlingual application of, [Mendel & others] 1574—ab
poisoning from, [Bornstein & Holm] 1825—ab
preparing by aqueous extraction, [Dodds & Dickens] 1082—ab, [Clough & others] 1889—ab
preparing, new method of, 805, 1279
recent literature on, [Seidl] 1998—ab
reduction in price of, 315
standardization of, 1742
substitute for, [González Rincones & Noguera Gómez] 166—ab
sugar in erythrocytes under, [Wiechmann] 756—ab
therapy in Czechoslovakia, 224
treatment with, [Pollak] 666—ab
treatment, hemorrhages after, [Ehrmann & Jacoby] 930—ab
treatment in toxemic vomiting of pregnancy, [Thalhimer] *636
treatment of preoperative and postoperative nonclabetic acidosis, [Fisher & Snell] *699
treatment with, in acidosis following trauma, [Glnsberg] *1517
units of, [Laqueur] 1308—ab
use of, in experimental medicine and surgery, [Mauriac & Aubertin] 1083—ab
INSULIN-STEARNS, 1937
INSURANCE: See also Workmen's Compensation
INSURANCE, chiropractors and life insurance examinations, [Camp] 738—C
for physicians, special form of, 984
health insurance, 2134
health insurance societies and physicians in Germany, 49, 224, 319, 406, 646, 732, 810, 904, 1061, 1212, 1282, 1378, 1459, 1562, 1626
information coming to medical examiner, 574—MI
life, and duodenal ulcer, [Forsyth] 1995—ab
medical overhaul every year, 1980
misrepresentations about having spit blood and having had influenza, 494—MI
new policy to indemnify physicians against claims for wrongful certification, 1133
"such immediate surgical relief as is imperative," 1719—MI
workman's, drawbacks of centralization in workman's insurance offices, 2134
INTARVIN, 51—P
INTELLECTUAL WORK, international intellectual cooperation, 139
brain work, 719—E
INTELLIGENCE and cranial capacity, 2060
INTERESTS, human, 1050—E
INTERNS, additional hospitals approved for training, 1716
fifth year; a retrospect, [Schmitt] 1074—ab
inquiry into demand and supply of, [Sanger] *992

INTERNS, intern as "employee" within compensation act, 915—MI.
problem of, [Faxon] 1073—ab
problem from standpoint of medical education, [Colwell] ★150
salaries paid to, by approved hospitals, 149
INTERTRIGO, gluteal erythema, [Kreutzer] 666—ab
hexamethylenamin in, [Simchen] 342—ab
INTESTINES; See also Cecum; Colon; Gastro-Intestinal Tract; Rectum
INTESTINES, absorption of, in rickets, factor of, 129—E
anastomosis, [Barr] 236—ab
anastomosis, isolation of submucosa in, [Graham] 1001—ab
anastomosis, side-to-side entero-anastomosis, [Santoro] 1006—ab
anomalies of intestinal rotation, [Dott] 63—ab
bacteria, effect of feeding on, [Goldman] 1893—ab
bacteria, nonhemolytic streptococci from intestinal tract, [Goldman] 1893—ab
bacteria, production of formaldehyd by, [Shaw] 1399—ab
bacteria, viability of, in fruits, [Vasquez-Colet] 1149—ab
bacterial flora of, [Goldman] 1893—ab
cancer of, lymph node involvement in, [Craig] 1478—ab
cancer of small intestine, [Traylor] 1810—ab
diverticulum, sciatic hernia; report of case of hernia of Meckel's diverticulum through greater sciatic foramen, [Brodnax] ★440
enterocyst causes intestinal obstruction, [Strode & Fennel] 499—ab
enterocystoma of duodenum, [Waugh] 499—ab
Epithelium, effect of roentgen rays on: See under Roentgen Rays
growth and length of, [Bryant] 1727—ab
hemorrhage from ulcer in small intestine in child, [Schreuder] 1236—ab
motility, suprarenal hormone and intestinal inhibition, [Tournade & others] 1401—ab
mucous membrane as barrier against bacterial invasion, 1267—E
Obstetrics: See also Volvulus
obstruction, acute, mechanical, treatment of, [Smythe] 1470—ab
obstruction, acute, in infants, [Rutherford] 1571—ab
obstruction, acute internal, [Haines] 237—ab
obstruction, acute, [West] 1471—ab
obstruction, Ascaris as cause of, [Levin & Porter] 923—ab
obstruction, cause of, [Ingvaldsen & others] 999—ab
obstruction caused by fold of broad ligament, [Pidcock] 1229—ab
obstruction, caused by ovarian cyst, [Wakeley] 825—ab
obstruction caused by roundworms following dosage of santonin, [Watkins & Moss] ★1442
obstruction, enterolith in sigmoid causes, [Miller & Neff] 917—ab
obstruction from ascarids, [Lafos García] 1484—ab
obstruction from gallstone in intestine, [Bonnecaze & Le Chaux] 1821—ab
obstruction in new-born, [Higgins] 64—ab
obstruction in parturient, [Hornung] 346—ab
obstruction, intermittent, [Tenney] 1729—ab
obstruction, lymphaticostomy in, [Costain] 1001—ab
obstruction, sodium chlorid in, [Haden & Orr] ★1515
obstruction, treatment of toxema of, [Orr] 238—ab
occlusion, simulation of tuberculosis and, [Brulé] 423—ab
paralysis, physostigmin and pituitary extract for postoperative intestinal atony, [Cross] 659—ab
Parasites: See also Amebiasis; Helminthiasis; Lamblia
parasites, infestation with flagellate protozoa, 1564—E
perforations of, traumatic, [Taylor] 1733—ab
peristaltic fatigue, 1367—E
protozoa, [Sydenstricker] 1811—ab
resection of fifteen feet of, [Sarnoff] 576—ab
roentgen study, Stierlin's phenomenon, [Sigmund] 1576—ab
small, sarcomas in, [Petersen] 346—ab
spasm, Ascaris lumbricoides causes, [Harris] 337—ab
spasm, enterospasm, [Körte] 1741—ab
stasis, chronic, [Lane] 924—ab, [Friedenwald] 1571—ab
stenosis, multiple, of small intestine, [Zeltner] 1743—ab
surgery of, with reference to underlying biologic principles, [Horsley] ★1159
syphilitic ulcer of, [Riggs] 238—ab
tuberculosis, calcium chlorid in treatment of, [Roberts] 1814—ab
tuberculous ulceration of, [Pritchard] 746—ab
tumor, lymphosarcoma of small intestine, [Kelley] ★785
INTESTINES, tumor of, vascular, [Brown] 238—ab
INTRACRANIAL PRESSURE changes, [Crothers] 499—ab
changes during convulsions, [MacDonald & Cobb] 582—ab
comparative values of magnesium sulphate and sodium chlorid for relief of, [Fay] ★768
dehydration and intracranial tension, 1270—E
evolution and prognosis of intracranial hypertension, [Arce & Balado] 929—ab
saline solution in cases of cerebral tumor, [Cohen] 1300—ab
INTUSSUSCEPTION, acute, in children, [Girode] 340—ab
caused by tumor, [Peple] 1650—ab
chronic primary, in children, [Marsh] 1145—ab
following fasting, [Mooro] 1150—ab
of sigmoid follows intussusception of appendix, [Blaxland] 2095—ab
subacute, [Bergstrom] 2079—ab
IODIDS, effect on tissues, [Kolmer & Lucke] 1146—ab
sodium, intra-arterial injection of, [Brooks] ★1016
sodium, intravenously in neuritis, [Stark] 579—ab
sodium, untoward results following intravenous injection of, [Isacson] 922—ab
IODIN content of sea foods, 327—ME
intravenous injections, value of, [Jeudwine] 581—ab
inverse relation between iodin in food and drink and goiter, [McClendon & Hathaway] ★1668
IONIZATION, anesthesia by iontophoresis, [Wirz] 1743—ab
electro-ionic medication, [Pack & others] 1991—ab
IONS, electrolytes in organism, [Kraus & others] 1901—ab
IONTHERAPY and mineral metabolism, 2064
IRELAND, an Irish problem, 2131
IRIDECTOMY: See also under Glaucoma
IRIDECTOMY, stenopeic, [Heine] 830—ab
IRIS, human, in health and disease, [Gilbert] 2093—ab
IRITIS, recurring, from gonococcus sepsis, [Sander-Larsen] 1576—ab
gonorrheal, [Chambers] 1995—ab
treatment of, with tuberculin, [Chambers] 245—ab
IRON deficiency, pathology of, and cotton seed poisoning, [M'Gowan] 1734—ab
in stools, elimination of, [Folkmar & Ulrich] 508—ab
iron treatment and oxygen consumption of erythrocytes, [Roessingh] 1826—ab
metabolism in infants, [Schwartz & others] 1234—ab
preparations, [Fischler & Paul] 1487—ab
IRREBOLIN, metabolin and pancreas, [Vahlen] 831—ab
ISLANDS OF LANGERHANS, tumor of, [Schneider] 1899—ab
separate organs, [Vincent] 2147—ab
ISO-AGGLUTINATION, new elements of, [Coca & Klein] 243—ab
ISO-AGGLUTININS in blood of new-born studies on, [Happ & Zeiler] 227—C
ISOLATION of women, execution of order for, 494—MI
IVY Poisoning: See Rhus poisoning

J

JACOBS, CHARLES, death of, 1797
JAPAN, hospitals destroyed in, 220
JAPANESE RIVER FEVER, [Faust] 751—ab
JAUNDICE, [Felsenreich & Satke] 664—ab
due to Bacillus aertrycke, [Anigestein & Millnska] 65—ab
catarrhal, phenylcinchoninic acid in liver affections, [Gunenberg & Ullmann] 2149—ab
epidemic, [Whitman] 1818—ab
hemolytic, chronic, [Weber] 1143—ab
hemolytic, familial, [Hatteson] 1472—ab
in eclampsia, [Oppenheimer] 588—ab
in new-born, [Pollitzer] 663—ab
in newborn, nature of, [Williamson] 1144—ab
Index, an aid in diagnosis and prognosis, [Bernheim] ★291
infectious, leptospirosis icterohemorrhagiae experimentally reproduced in Ecuador, [Carbo-Noboa] 1998—ab
Kupffer cells in, [Kanmer] 665—ab
spirochetal, [Gulland & Buchanan] 1150—ab
uric acid excretion in, [Ullmann] 252—ab
with duodenal ulcers, [Bickel] 239—ab
yellow urticaria in, [Jadassohn] 427—ab
JAW tumor, adamantine epithelioma of, [Horsley] 1393—ab
tumor, myeloma of alveolus after trauma, [Kittel] 1897—ab
tumors of, [Bloodgood] 1643—ab
upper, osteomyelitis of, in infants, [Nord] 1576—ab
JEJUNUM, false diverticula of, [Sheppe] ★1118
melanoma, apparently primary in jejunum, presenting symptoms resulting from metastasis in hypophysis cerebri, [Cox & Sloan] ★2021
Ulcer: See Peptic Ulcer
JERIE, JOSEPH, becomes professor of obstetrics, 646
JEWISH RACE, address on numerus clausus, 1060
predelection of phenolphthalein eruptions for Jews, [Hailey] 2145—ab
JOINTS: See also Pneumarthrosis
JOINTS, deposits of calcium around, [Stegemann] 342—ab
loose bodies in, cause of, [Phemister] 1817—ab
neuro-arthropathies; form caused by peripheral nerve disease or injury, [Phillips & Rosenheck] ★27
sensitization of, with nonhemolytic streptococci, [Swift & Boots] 61—ab
tuberculosis, heliotherapy in, [O'Reilly] 1000—ab
tuberculosis, local treatment of, [Pattison] 584—ab
tuberculosis, roentgen-ray in, [Petersen & Hellmann] 2149—ab
tuberculous, treatment of, [Schwartz] 921—ab
JOURNALS, Archivos de Endocrinologia, 1403—ab
American Journal of Pathology, 1873
Annali di Clinica Terapeutica, 1453
Australian Journal of Experimental Biology and Medical Science, 1792
Belgian, republication of, 986
Bulletin médical du Katanga, first medical journal in Congo, 1625
Bulletin de la Société belge d'histoire de la médecine, 561
Bulletin d'histologie appliquée à la physiologie et à la pathologie et de la technique microscopique, 986
Bulletin of the Belgian Society of Dermatology and Syphilology, 2132
Journal de Médecine de Bordeaux, 904
Journal of Cancer (Irish), 1453
Journal of Cancer Research, 984
Le Médical, daily medical journal, 644
medicoliterary journal, 223
Memphis Medical Journal, 480
Revue médicale de France et des colonies, 561
Revue du trachome, new medical journal, 1375
"Rinascenza Medica," 1006—ab
JUDGMENT, biased, diagnosis, treatment, damages, 654—MI
JURISPRUDENCE: See Medical Jurisprudence

K

KAHN TEST for syphilis, [Havens & Taylor] 1645—ab, [Osmond & McClean] 1651—ab
value of, [Elliott & Todd] 1145—ab, [Keim] 1813—ab
KALA-AZAR: See Leishmaniasis
KANSAS CITY COLLEGE of Medicine and Surgery, Kansas City, Mo., 1219
KAUFFMANN'S CIRCULATION TEST: See under Diuresis
KERATITIS, interstitial, roentgenotherapy of, [DeCourcy & Mather] 659—ab
KERATOMALACIA, etiology of, [Stransky] 1307—ab
fatal case of, in infant, [Wilson & DuBois] 239—ab
in children, [Hamburger] 167—ab
KETOSIS: See Acidosis
KIDNEYS, actinomycosis of, primary, [Abbott] ★1414
ammonia formation in, significance of, 1697—E
anomalies, unilateral fused kidney, [Dourmashkin] ★2025
atrophy, relation of blood pressure to amount of renal tissue, [Anderson] 1992—ab, 2123—E
calculi, bilateral, [Razetti] 69—ab
calculi, acute inflammation from, [Livingston] ★1495
calculi, bilateral, calcification of renal vein with, [Stirling & Lawrence] ★25
calculi, focal infection causes, [Bursey] 1228—ab
calculi, large, [Vossbeck] 757—ab
calculi, present 60 years, [Barnett] 999—ab
calculi, renal fluoroscopy for, [Braasch & Carman] 1649—ab
calculi, resection of kidney in, [Young] 658—ab
calculi, roentgenogram of, [Reschke] 2149—ab
cancer of, [Allemann & Bayer] 667—ab
cancer, papillary, [Seely] 923—ab
cancer, papillary epithelioma of kidney pelvis, [Eggers & Felsen] ★1415
carbuncle in, [Colmers] 1157—ab
cells, reaction of, [Stieglitz] 1729—ab
circulatory changes in hydronephrosis, renal tuberculosis and polycystic kidney, [Hinman & Morison] 1226—ab
congested, [Klein] 589—ab
contracted, prognosis of, [Dubois] 1158—ab

KIDNEYS, cyst, familial cystic kidney, [Sprent] 1003—ab
cyst, large, [Simoncelli] 1085—ab
decapsulation of, in acute anuria, [Hoffmann] 1574—ab
ectopic, in lumbar region, [Baggio] 425—ab
effect of antisyphilitic treatment on, [McFarland] 1727—ab
Function: See also under Diuresis; Urea; Urine
function, relations between glycemia, blood pressure and, [Aiello] 1305—ab
function tests, [Rosenberg] 665—ab, [Longcope] 1299—ab
function tests, creatinin, [Major] 655—ab
function tests, diastase determinations a measure of, [Stafford & Addis] 825—ab
function tests, phenolsulphonephthalein, [Bazy] 340—ab
function tests, value of, in nephritis, [Crawford] 1082—ab
gonococcal infection of, [Johnson & Hill] 1226—ab
infarcts, uric acid infarcts in infants, [Armbruster] 1235—ab
infection due to Micrococcus pharyngitidis-siccus, [Kretschmer & Hufnagel] *1850
influence of insulin on behavior of, in respect to glucose, [van Creveld & van Dam] 170—ab
injuries, treatment of, [Bailey] 2085—ab
innervation, resection of nerves of, [Papin & Ambard] 1731—ab
insufficiency, blood calcium in, [Zondek & others] 1090—ab
liver-kidney syndromes, [Parturier] 1821—ab
pain, neurectomy of renal nerves, [del Pino & Astraldi] 250—ab
pelvis, pyelovenous back flow; its relation to pelvic reabsorption, [Hinman & Lee-Brown] *607
permeability, relation of glycosuria to, [John] 418
permeability, renal glycuresis, [Finley & Rabinowitch] 2086—ab
physiology, theory of secretion of urine, [Bieter & Hirschfelder] 1889—ab
regeneration, studies in, [Kupel] 1078—ab
rupture of, in hydronephrosis, [Reschke] 2092—ab
secretion, calculous anuria, [Melen] *520
secretion, localization of excretion in uriniferous tubule, [O'Connor & McGrath] 1301—ab
supernumerary, uroptysis, [van der Speck] 254—ab
suppression of urine with necrosis of renal cortex, [Cruickshank] 246—ab
surgery, blood changes after, [Kolke] 1576—ab
surgery, under paravertebral anesthesia, [Lowsley & Pugh] *1011
surgery of, under regional anesthesia, [Lowsley] 1644—ab
tuberculosis, [Löwenstein & Moritsch] 506—ab, [Bandel] 1405—ab
tuberculosis, alleged cures of, [Lévy] 424—ab
tuberculosis, early diagnosis of, [Colmers] 1157—ab, [Hryntschak] 1659—ab
tuberculosis, elimination of tubercle bacillus by kidneys, [Hobbs] 247—ab, 423—ab
tuberculosis, function of tuberculous kidney, [Wildbolz] 586—ab
tuberculosis, nephrectomy in, [Suter] 249—ab, [Cifuentes] 1998—ab
tuberculosis, nitrogen metabolism in, [Agrifoglio] 1900—ab
tuberculosis, possible errors in diagnosis of, [Braasch & Scholl] *688
tuberculosis, suprapubic cystotomy in, [Rathbun] 1300—ab
tuberculosis, surgery in, [Judd & Scholl] 236—ab, 1393—ab, [Heiderich] 1739—ab
tuberculous fistulas after nephrectomy, 731
tumor, thrombosis and embolism resulting from, [Judd & Scholl] *75
tumors, multiple miliary adenomas of kidney cortex, [Turley & Steel] *857
tumors, papillary, [Scholl] 1001—ab
urinary incontinence from third ureter, [Schoenholz] 507—ab
KING'S RADIUM FRAUD, 1215—P
KNEE injuries, easily curable knee affection, [Sadoli] 1406—ab
injuries of, [Bircher] 165—ab
injury, separation of quadriceps from patella, [Zadek] 921—ab
surgery of, [Campbell] 922—ab
traumatic (?) effusion in, [Gram] 1576—ab
treatment of traumatism of, [Semb] 430—ab
tuberculosis of, in China, [Stearns] 337—ab
KNIFE, new plaster knife, [Philips] *31
KOCH, ROBERT Koch's diary, [Kleine] 587—ab
KÖHLER'S DISEASE, history of, [Köhler] 831—ab
KOLMER TEST, [Kilduffe] 1474—ab
and Wassermann, [Irvine & Stern] 822—ab
as specific test for syphilis, [Hartman & Reyner] *196
KÖNIGSTEIN, PROFESSOR, death of, 646
KOTTMAN REACTION: See under Hyperthyroidism; Thyroid
KYPHOSIS from tetanus, [Wilhelm] 67—ab

L

LABOR: See also Obstetrics
LABOR, abdomen window births, [Ludwig & Lenz] 756—ab
breech presentation, injury of fetus in hastening, [Salen] 1232—ab
court penalizes tardy physician, 1210
delivery of shoulder, [Kickham] 418—ab, [Abernethy] 1234—ab
dystocia caused by Bandl's ring, [Vogel] 1085—ab
extensive sloughing during, [Ridler] 1302—ab
forceps, birth dislocation of eyeball from, [Gerdes] 1233—ab
forceps, axistraction, case against, [Hirst] *296
forceps, Kielland, [Henkel] 755—ab, [Pruska] 1910—ab, [Wyder] 1403—ab
forceps, use of, by midwives? [Coquet] 1004—ab
glucose by rectum in first stage of, [Rucker] 498—ab
hemorrhage from placental site, arrest of, [Brock] 1735—ab
induction of, [Druskin] *370
Mortality: See Maternal Mortality
obstruction by cervix during, 1067
pituitary extract in, [Steinberg] 819—ab
sudden death in, [Schickelé] 1304—ab
trend of modern obstetrics wrong, [Anspach] 239—ab
LABORATORY, erroneous interpretation of blood test by employee, 1387—MI
new biochemical laboratories at Cambridge, 1876
service, efficient, in hospital or community, [Barret & Richardson] *113
students' unit, medical laboratory, [Leake] *114
tables, staining solution for, 1802
LABYRINTH: See under Ear; Vestibular apparatus
LACQUER Dermatitis: See Dermatitis venenata
LACRIMAL PASSAGES, treatment of, [Lidstrom] 1010—ab
LACRIMATION, simple, radical treatment of, [Saint-Martin] 927—ab
LACTASE, [Freudenberg & Hoffmann] 71—ab in adult intestine, [Marx] 1824—ab
LACTATION and lack of vitamins, [Eckstein & Szily] 588—ab
beginning of, [Heckmann & Opitz] 1741—ab
influence of thyroid on increased heat production during, [Marine] 1726—ab
persisting, [Mozafion] 1306—ab
LAMBLIA INTESTINALIS infection, treatment of, [Knighton] 1993—ab
LANCING, refusal of, 574—MI
LAPAROSCOPY: See Abdomen, examination
LARYNX cancer, adenocarcinoma of larynx secondary to kidney tumor, [Turner] 1572—ab
cancer, intrinsic, [Fraser & Watson] 925—ab
chronic stenosis of, [Klaue] 343—ab
heliotherapy of, [Samengo] 167—ab
myxedema of, [Josephson] *108
roentgen-ray changes in, [Strandberg] 1236—ab
tuberculosis, chaulmoogra oil for, [Bronfin & Markel] 332—ab
tuberculosis of, Finsen light baths for, [Strandberg] 338—ab
tuberculosis of, treatment with electric light, 1281
LATIN no longer compulsory for M.R.C.P., 2131
LEAD, hygiene in type-foundries, [Seitz] 428—ab
influence of, on cell growth, [Bell] 1002—ab
orchitis, [McCord & Minster] *1104
poisoning, [Sandig] 1744
poisoning, basophilia aggregation test in, preliminary report, [McCord & others] *1759
poisoning, diagnosis of, [Teleky] 1233—ab
poisoning, fatal convulsions in children whose father had, [Thomson] 750—ab
poisoning from storage batteries, 1383
poisoning in children, with special reference to pica, [Ruddock] *1682
poisoning, serous meningitis in infants from, [Suzuki & Kaneko] 1819—ab
LEAGUE OF NATIONS and narcotics, 727
Committee of Public Health, representation of Spain on, 1625
Committee on Hygiene, 1059
Health Committee, 1453, 1980
to investigate traffic in women and children, 136
LECTURES delivered by American physicians, 2062
"university group" of, 904
LEFT-HANDEDNESS, secondary, [Neurath] 1156—ab
LEG: See also Extremities; Fractures
LEG, cramps in, 148, 412
damages allowed for losses of legs, 915—MI
to shorten, [Maxeda] 1087—ab
LEGRAND DU SAULLE, in memory of, 1456
LEISHMANIA donovani, staining, in tissues, [De] 1151—ab
LEISHMANIA, tropica, cultivation of, [Kligler] 918—ab
LEISHMANIASIS, blood in, gelatinization of, [de Capite] 1656—ab
blood in, plasma proteins in, [Barberi] 1656—ab
criteria of cure in, [Struthers] 1896—ab
cutaneous, [Brahmachari] 666—ab
formol-gel test for, [Elwes & others] 2085—ab
globulin precipitation test in, [Sia] 1082—ab
globulin precipitation and formol-gel tests in, [Struthers & Ch'un] 1896—ab
in children, [Giraud & Zuccarelli] 1482—ab
in Spain, [Iglesias Garza] 251—ab
transmission by bed-bugs, [Shortt & Swaminath] 1652—ab
urea stibamine in, [Brahmachari] 161—ab, [Short & Taran Sen] 162—ab
urine cultures in, [Napier & Das Gupta] 245—ab
LENS as seen with Gullstrand slit lamp and corneal microscope, [Bedell] *363
precipitins, [Hektoen & Schulhof] 1892—ab
LENTILS, favorite vegetarian foods, 2052—E
LEO, PROFESSOR, 70th birthday of, 1282
LEONTIASIS ossea, [Knaggs] 64—ab
LEPERS, amendment to regulations governing, 803
China establishes colony for, 1452
leper case probed; trial for murder, 39
LEPROSY and tuberculosis, [Rogers] 1156—ab
antimony in, [Rodriquez & Eubanas] 1080—ab
campaign against, 728
eye lesions in, [Fernando] 159—ab
incubation period of, [Rogers] 1156—ab
initial lesion of, [Gomez] 159—ab
is self-healing, [Muir] 1002—ab
problem, 1622
serodiagnosis of, 298—ab
sporadic case developing in Pennsylvania, [Holderman] *1927
transmission of, [Muir] 581—ab, [Valverde] 2090—ab
transmission by mosquito, [Gomes] 753—ab
transmission by rats, [Marchoux] 248—ab
treatment, [Muir] 162—ab, [Para & Santos] 1484—ab
treatment at Culion, [Wade] 159—ab, [Lhara] 159—ab
LEPTOSPIRA icteroides, [Wanstrom] 1078—ab
LEPTOSPIROSIS ICTEROHEMORRHAGIAE: See under Jaundice
LEPTOTHRIX of Verhoeff, Parinaud's conjunctivitis with demonstration of, [Lemoine] *537
LEUKEMIA, acute, [Aubertin & Grelley Bosviel] 163—ab
acute, and mononcleosis, [Russell] 1641—ab
acute, in children, [Morquio] 426—ab, 828—ab
acute myelosis after bees' stings, [Parrisius & Heimberger] 1046—ab
acute myelocythemia and chloroma, [Goodall & Alexander] 825—ab
atypical, [Gutmann] 1991—ab
leukemic leukolysis, [Szilárd] 1743—ab
lymphatic, of skin, [Van Gay] 334—ab
myelogenous, chronic, irradiation in, [Minot & others] *1489
myelogenous; chronic, radium treatment of, [Bigger] 83—ab
radium therapy of, [Aikins] 340—ab
serum in, [Sabrazès & Muratet] 584—ab
LEUKOCYTES: See also Lymphocytes
LEUKOCYTES, Arneth blood picture in tropics, [Banerjee] 1733—ab
count, limits of error in, [Ockel] 1308—ab
count, differential, [Schilling] 1090—ab
hematology of parturition, [Saidi & Tuma] 1010—ab
monocytes in exudates, [Schilling & Bansi] 1090—ab
neutrophil, in pulmonary tuberculosis, [Stephani & Stephani] 1232—ab
physiology of, [Pollicard] 248—ab
sedimentation speed of, [Schilling & Schulz] 334—ab
trephones, [Carrel] *255
trephones, growth-promoting substances, 549—E
LEUKOCYTOSIS, the vagus and septic diseases, [Müller] 73—ab
after "psychic meal," [Glaser] 1826—ab
LEUKOPENIA, anaphylactic, mechanism of, [Webb] 824—ab
in infections, significance of, [Sison & Lara] 580—ab
LEUKOPLAKIA in bladder, [Li Virghi] 827—ab
LEUKORRHEA in virgins, [Brose] 2150—ab
LEVADITI, visit of, to Prague, 1377
LIABILITY, joint, 416—MI
charitable corporations—action of orderly in hospital, 2143—MI
for both injury and malpractice—sewing garter buckle in wound, 2076—MI
negligence imputable to operating surgeons, 2143—MI
of one spouse for services to the other, 2143—MI
"such immediate surgical relief as is imperative," 1719—MI

LIBRARIANS, school for, in Paris, 1875
LIBRARY of modern medical school, [Gilchrist] *1287
LICENSURE: See also State Boards
LICENSURE, affidavits not conclusive on medical board, 818—MI
Annual Congress on Licensure, etc., 307—E, 798, 890, 972
College of Physicians and Surgeons, Boston, 1140
diploma inquiry continued, 214, 978, 1698
diploma mills, pharmacy, 40
diploma mills, committee on, 312
diploma-mills, Connecticut's investigation of, 1365—E
diploma mills, Kansas City College of Medicine and Surgery, Kansas City, Mo., 1219
law violated by chiropractor, sentence to hard labor, 494—MI
new medical practice act, 141
"physicians and surgeon" and "naturopath" defined, 1293—MI
powers of medical board not changed, 916—MI
practitioner without an "M.D." degree in Austria, 810
prosecution for practicing without certificate, 58—MI
qualifications of examiner for, 973
registration of physicians, 639
St. Louis College of Physicians and Surgeons, 1140
why reciprocity? [Crowe] 973—ab
LICHEN pilaris seu spinulosus, [Wallhauser] 821—ab
planus, treatment of, 412
LIFE, Duration of: See Longevity
LIGHT: See also Heliotherapy
LIGHT, action of, on blood, [Ramain] 163—ab
and blood platelets, 212—E
and growth, 791—E
effect of, on organism, [Cramer & Drew] 160—ab
environment, growth and light, [Degkwitz & others] 1008—ab
light baths and blood calcium, [Rothman & Callenberg] 71—ab
radiation and bactericidal power of blood, 2123—E
sunlight kills tube cultures, [Lal] 162—ab
Therapy: See Heliotherapy; Phototherapy; Ultra Violet Ray
LIMBS: See Extremities; Arms; Leg
"LIME STARVATION" REDIVIVUS, 489—P
LINCOLN "UNIVERSITY," 38
LINK'S GOLDEN TONIC, 989—P
LINOSSIER, GEORGES, death of, 138
LIP cancer, malignant furuncle of, [Roedelius] 506—ab
cancer, model of, reconstructed from serial section, [Warwick] *1119
infections of, [Kahn] *1043
tuberculous ulcer of, [MacPherson & Gregg] *966
LIPASE in human stomach, [Takata] 757—ab
in Blood: See under Blood of serum and liver, [Broekmeyer] 2092—ab
LIPEMIA RETINALIS, effect of insulin in diabetic lipemia with, [Rowe] *1168
LIPODYSTROPHIA progressiva superior with ovarian dysfunction, [Boston] 244—ab
LIPOMA of thigh, [Speed] 237—ab
retropharyngeal, [Woods] 924—ab
temperature of skin over, [Burrows] 422—ab
LIPOSAN, 1462
LIQUOR: See also Alcohol; Prohibition
LIQUOR, corn, called "poison"—crazed by "dope," 1805—MI
U. S. Supreme Court on medicinal use of malt liquors, 2054—E
LISTER memorial, 1058, 1133
Lister's ward, demolition of, at Glasgow Infirmary, 805
LIVER, abscess, aspiration of, [Neligan] 583—ab, [Ludlow] 1479—ab
abscess of intestinal origin, [McGrath] 748—ab
amebic abscess of, [Ciotola] 341—ab
anaphylotoxin; hepatic internal secretion in anaphylaxis, [Manwaring & others] *1504
and diuresis, [Adler] 72—ab
and roentgen injury, [Neuda & Redlich] 253—ab
ascariasis of intrahepatic bile ducts, with calculus formation, [Motta] *85
atrophy, etiology of, [Miller & Rutherford] 66—ab
atrophy of, senile, [Zeckwer] 1731—ab
bilirubin determinations in blood as a measure of liver damage in treatment with arsphenamins, [Schamberg & Brown] *1911
changes in fasting animal, [Rous & McMaster] 1396—ab
cirrhosis, Hanot's, [Steinfield & Kohlman] 1894—ab
cirrhosis, infantile biliary, [Da Costa] 581—ab
cirrhosis, ascites and jaundice in, [Fiessinger & Brodin] 1005—ab
cirrhosis and severe valvular lesion in child, [O'Donnell] 1480—ab
cirrhosis in men and women, [Chauffard & Brodin] 1996—ab
cirrhosis, restriction of alcohol and, 117—ab
cirrhosis, sarcoma and carcinoma of liver following, [Jaffe] 1296—ab
LIVER disease in gallstone disturbances, [Tietze & Winkler] 1657
disease, liver-kidney syndromes, [Parturier] 1821—ab
disease, pathologic intermittence in functional rhythm in, [Fiessinger & Walter] 1898—ab
echinococcosis, [Fairley] 1400—ab
extirpation of, [Perroncito] 1483—ab
fatty enlargement of, acute in infants, [Kohn] 1473—ab
fatty infiltration of, cause of, in tuberculosis, [Goldberg] 333—ab
function, effect of arsenic on, [MacCormac & Dodds] 500—ab
function, excretory, [Brugsch & Horsters] 2149—ab
function, intermittent function of normal livers, [Fiessinger & Walter] 1821—ab
function test, and toxemias of pregnancy, [Berkeley & others] 1652—ab
function test, levulose, [Tallerman] 66—ab
function test, determination of phenoltetrachlorphthalein in blood serum, [Bloom & Rosenau] *547
function test, phenoltetrachlorphthalein, [Hozie] *361, [Gilbert & Coury] 1230—ab
function test, phenoltetrachlorphthalein, in syphilis and skin diseases, [Greenbaum & Brown] *88
function test, Rosenthal, in obstetrics, [Krebs & Dieckmann] 819—ab
functioning, influence of arsphenamin on, [Kartamischew] 1824—ab
hepatitis with chronic abdominal infection, [Heyd & others] 1728—ab
in the splenectomized, [Schmidt] 1405—ab
insufficiency of, 1211
process and syphilitic skin, [Kramer] 2150—ab
resection of, [Lilwen] 1739—ab
tumor, congenital, [Lagos Garcia] 1573—ab
LOCOMOTOR ATAXIA: See Tabes Dorsalis
LOEB, JACQUES, 722
LOEFLUND'S MALT SOUP STOCK (DR. KELLER'S FORMULA), 303
LONDON SCHOOL OF HYGIENE, 1373
LONDON SCHOOL OF MEDICINE FOR WOMEN, women in medicine; jubilee of, 1621
LONGEVITY: See also Old Age
LONGEVITY, factors influencing, [Pearl] *259
promise of longer lifetime, 1518—E
LUMBAGO, [Zollinger] 1738—ab
LUMBAR PUNCTURE: See Rachicentesis
LUMBOSACRAL REGION; anatomic study and some clinical observations, [von Lackum] *1109
LUNG abscess, [Lambert & Miller] 823—ab, [Langenskiöld] 832—ab
abscess, nontuberculous, [Whittemore] 1478—ab
abscesses, spirochetal, [Rawson] *545
accessory, [Pineda] 1149—ab
arborization in, [Garcin] 1230—ab
blood in, amount of, [Drinker & Wearn] 2077—ab
cancer of, with stomach symptoms, [Leitz] 156—ab
cancer of, physical diagnosis of, [Neumann] 2093—ab
collapse, postoperative massive, [Leopold] 1474—ab
cysts in, proliferation of epithelium and formation of, [Oudendal] 1828—ab
disease, anatomic findings in cases simulating tuberculosis, [Rusk & Randolph] *442
disease, chronic, unusual organism (Alternaria, sp.) occurring in, [Wahl & Haden] *162
echinococcus cysts of, 1376
edema, treatment of, [Zimmer] 587—ab, [John] 1658—ab
foreign bodies in, glass beads and other hollow objects removed, [Aynesworth] *1441
gangrene, [Rosenthal] 340—ab
Hemorrhage: See also Hemoptysis
hemorrhage, [Hudson] 1003—ab
suppuration, nontuberculous, treatment of, [Hedblom] 749—ab
suppuration, bronchoscopic treatment of, [Moore] *1036
syphilis, [Borges Pereira] 587—ab, [Howard] 1075—ab
Tuberculosis: See Tuberculosis, Pulmonary
tumor, roentgenotherapy of malignant metastases, [Evans & Leucutia] 820—ab
Vital Capacity: See under Vital Capacity
LUPUS erythematosus, [Macleod] 1076—ab
erythematosus and chronic prostatitis, [Burke] 162—ab
pernio, sarcoid of Boeck and, [Martenstein] 1824—ab
von LUSCHAN, FELIX, death of, 905
LYE: See also under Esophagus
LYE poisoning, Salzer's treatment of, [Bókay] 1486—ab
LYMPH pressure, measuring, [Lee] 997—ab
LYMPH NODES, diseases of, [Krecke] 931—ab
epitrochlear, enlargement of, [Grenier] 340—ab
hilum, effect of enlargement of, on lymph flow, 1583—ab
LYMPH NODES, inflammation, copper salts in, [Carnot & Froment] 1402—ab
inflammation, malignant, roentgen irradiation in, [Cramer] 1404—ab
inflammation, vaccine therapy of, [Chevrier & others] 1997—ab
inguinal, extirpation of, [Neuwirt] 429—ab
mesenteric, simple inflammatory swelling of, [Heusser] 70—ab
misleading primary cancer of, [Gioja] 341—ab
pelvic, leukosarcomatosis of, [B'att] 1157—ab
subepithelial, immunizing function of, [Digby] 65—ab
tracheobronchial adenopathy, vital capacity in, [Wilson & others] 575—ab
tuberculous, treatment of, [Neve] 162—ab, [Sorrei] 1004—ab
tuberculosis, in children, [McEachern] 577—ab
LYMPHADENOMA, menstruation and pregnancy in, [Gemmell] 246—ab
LYMPHANGITIS, tuberculous, and adenitis in interspaces, [Wertheimer] 928—ab
LYMPHATICOSTOMY in intestinal obstruction, [Costain] 1001—ab
in puerperal infection, [Edwards] 1001—ab
LYMPHOCYTES, action of serum on, in vitro, [Carrel & Ebeling] 61—ab
small, and spleen, [Lee] 1396—ab
LYMPHOCYTOMA, retroperitoneal, causing chylous ascites and chylothorax, [Coley] *2031
LYMPHOCYTOSIS, sepsis as cause of, [Tidy] 825—ab
LYMPHOGRANULOMA, blood counts in, [McAlpin] 417—ab
enlargement of abdominal lymph nodes characteristic of, [Symmers] 1473—ab
leukocytes in, [Weiss] 1743—ab
malignant, paraplegia in, [Weber] 66—ab
pathogenesis of, [Kuczynski & Hauck] 1090—ab
prognosis of, [Klewitz & Lullies] 1007—ab
roentgenotherapy in, [Arrillaga & Merlo] 754—ab
treatment of, 1103—ab
tuberculosis as cause of, [Lemon] 1143—ab
LYMPHOMA of orbit, radiotherapy of, [Tiscornia] 1306—ab
LYMPHOSARCOMA, cervical, [Thomson] 751—ab
LYSINS of serum, action of, [Poyarkoff] 1898—ab

M

MACEWEN, WILLIAM, father of brain surgery, 1278
MACULA LUTEA, coloboma of, [Janku] 253—ab
MADRID MEDICAL SCHOOL, 1878
MADURA FOOT: See Mycetoma
MAGNESIUM, metallic, inhibits bacterial growth, [Seelig] 1224—ab
sulphate for intracranial tension, [Fay] *766
MAH JONGG sets, dermatitis venenata from, [Levin] *465, [Zeisler] *466
MALARIA and neurosyphilis, [Bercovitz] 1713—C
antimalaria crusade in Holland, 1707
artificial importation of, into Denmark, 721—E
blackwater fever with, [Young] 337—ab
chronic, cause of acne and asthma, [Murray] 2145—ab
chronic, caused by plasmodium falciparum, [Huck & Bowden] 1730—ab
congenital, [Trimble] 1479—ab
danger of neo-arsphenamin in syphilitics with, [Marinesco & Draganescu] 423—ab
diagnosis of typhoid and, [Fronticelli] 1483—ab
epidemiology of, in Russia, [Mackenzie] 338—ab
first onset of, [Korteweg] 1744—ab
in Palestine, [Kligler] 1391—ab; 2120—E
in Russia, 982
in Spain, 1624
Liverpool studies in, 796—E
monocytosis in, [Meo-Colombo] 2089—ab
parasite of chimpanzee, [Blacklock & Adler] 1994—ab
pernicious, diagnosis of, [Photakis] 1740—ab
pernicious, in Panama, [Brem] 332—ab
Pittaluga discusses malaria, 1878
quinin acid hydrobromid for, [Acton & Knowles] 2085—ab
relation of, to altitude, [Gill] 162—ab
retinal hemorrhage in, mixed quinin and arsenical treatment of, [Canitano] 1997—ab
serodiagnosis, biologic tests in, [Businco & Foltz 2089—ab
splenic index determines degree of, [Boyd] 918—ab
tertian, benign, [MacRae] 1151—ab
treatment of, [Dixson] 1003—ab
treatment, quinin intravenously in, [Cantlie & Moubarak] 1151—ab, [Basrahmachari] 1733—ab
treatment, "self-defensive reaction," [Manoukhin] 825—ab

MALARIA, treatment, resistance of, to quinin, 1125—E, [Shuman] 1382—C
Treatment with Malaria: See Paralysis, progressive
zoophilism of Anopheles in relation to, [Cragg] 660—ab
MAL DEL PINTO in Yucatan, [Rodriquez Arjona] 1085—ab
MALINGERING, simulation of tuberculosis and intestinal occlusion, [Brulé] 423—ab
MALNUTRITION: See Nutrition, disturbances
MALPRACTICE, alleged, burden of proof in action for, 1638—MI
and broken needles, 1805
leaving adjustments to patient—making few examinations, 416—MI
liability for both injury and malpractice—sewing garter buckle in wound, 2076—MI
negligent treatment of hand for broken needle—testimony of attendant, 233—MI
no competent evidence of negligence introduced, 1806—MI
manipractor held liable for malpractice—evidence, 1221—MI
treatment of wound—evidence of negligence, 2144—MI
MALTA FEVER germ and bacillus abortus, immunologic identity of, [Auricchio] 663—ab
in Baltimore, [Keefer] 747—ab
in environs of Paris, 485
treatment of, [de Partearroyo] 930—ab
MANDIBLE: See Jaw
MANGE not transferable from dog to man, 325, 491
MANIA, massage in psychomotor excitement, [Stanojevic] 429—ab
MANSLAUGHTER, production of criminal miscarriage, manslaughter, 1806—MI
MARATHON RUNNERS, heart and blood vessels of, [Gordon & others] 1729—ab
some changes in chemical constituents of blood following marathon race, with special reference to hypoglycemia, [Levine & others] *1778
MARINE hospital service, 1453
MARRIAGE, adultery; what is law for man is also law for woman, 154—ML
bill to prohibit racial intermarriage passes house, 1275
not annulled for concealing epilepsy, 1069—MI
of poverty, ban on, 1793
physical examination before, 1211
MASSEURS, state control of, 1213
MASTITIS, infection of nursling from, [Runge] 507—ab
treatment of, [Rucker] *870
MASTOIDITIS with occipital abscess, [Anderson] 247—ab
without apparent involvement of middle ear, [Heggie & Knauer] *1044
MATAMEL 1139
MATERNAL mortality, causes of, [Baughman] 1650—ab
mortality, death rates from childbirth, 1922, 42
mortality too high in England, 1455
mortality, results of investigation of causes of, [Elchel] 1567—ab
MATERNITY Act, Secretary of Labor approves extension of, 1276
bonus in Australia, 902
MAXILLARY SINUS, chronic inflammation of, [Worms] 927—ab
MEAD'S POWDERED PROTEIN MILK, 1781
MEASLES associated with diphtheria, [Reiche] 252—ab
bed isolation for chickenpox and, [Harries] 1229—ab
etiology of, [Arloing & Dufourt] 1653—ab
etiology, agent of, in urine and exanthem, [Rossa] 1305—ab
prophylaxis by serotherapy, [Rietschel] 167—ab, [Weaver & Crooks] *204, [Cambessédès & Goannon] 424—ab, [Zingher] *1180, [Peseths] 1477—ab
sequels of, [Southby] 2147—ab
transmitted by blood transfusion, [Bauguess] 1223—ab, 1448—E, [Harrell] 1812—ab
treatment of, [Zahorsky] 1000—ab
without exanthem, [Krasemann] 1308—ab
MEAT consumption in Germany, 224
diet, renal injury caused by, [Newburgh & Clarkson] 417—ab
inspection of, 1625
MECKEL'S DIVERTICULUM: See Intestines
MECKEL'S GANGLION, control of earache of laryngeal origin through nasal ganglion, [Clerf] *630
MEDALS: See Prizes
MEDIASTINITIS, adhesive, electrocardiogram in diagnosis of, [Carter & Dieuaide] 2077—ab
MEDIASTINUM, compression, chronic fibrinous bronchitis as symptom of, [Mulligan & Spencer] *791
neoplasms of, in children, [Rosenson] 239—ab
posterior, treatment of suppuration in, [Lerche] 823—ab
sarcoma of, [Jeffrey] 1396—ab
tumors of, in children, [Smith & Stone] 2080—ab.
MEDICAL COMMISSIONS, in Belgium, 1796
MEDICAL JURISPRUDENCE, Congress of Legal Medicine, 223
dental opinion in criminal cases, 1623
forensic medicine in cases of dubious responsibility, 1281
medicolegal examinations by stomatologists, 1623
new branch of legal medicine, 1209
MEDICINE: See also Education, Medical; Fees; etc.
MEDICINE, American, Austrian views of, 140
and community of scientific thought, 968—E, [Merriam] 1138—C, [Van Dyke] 1139—C
and meteorology, 1445—E
and physicians, 404
history, selections from "Book of Joseph," [Lichtwardt] *652
medical outlook, [Fancher] 1469—ab
military, British Medical Service in the War, 1622
preventive, individualized longevity promotion, [Exton] *591
preventive, undergraduate course in, [Lentz] 892—ab
psychology in medical practice and legislation; professor's duty to itself and to the nation, [Eagleton] *2100
social, new chair of, 1626
social problems of, [Pusey] *1905
specialization in, 1575
state, principles of organization of Public Medical Relief Service in Sweden, [Nordenson] 590—ab
MEGACOLON: See Colon
MEINECKE TEST, comparative value of Wassermann and, [McGlumphy] 1731—ab
MELANOMA apparently primary in jejunum, presenting symptoms resulting from metastasis in hypophysis cerebri, [Cox & Sloan] *2021
MELANOSIS, diffuse, [Friedrich] 169—ab
MELANURIA, 37—E
in absence of melanotic tumor, [Haden & Orr] 1147—ab
significance of, 889—E
MELENA, treatment of, [Rochat] 249—ab
MENIÈRE'S DISEASE: See under Vertigo
MENINGES, gliomatosis of leptomeninges, [Firor & Ford] 1730—ab
primary sarcomatosis of leptomeninges, [Ford & Firor] 1395—ab
MENINGISM, azotemic, [Pecegueiro] 1998—ab
MENINGITIS, acute gummatous, [Polleri] 165—ab
acute purulent perimeningitis, [Keienburg] 2093—ab
colon bacilli, [Sickenga & Munk] 2150—ab
distribution according to age and etiology, [Neal] *1429
drainage routes in, [Ayer] 1299—ab
due to micrococcus catarrhalis, [Garland] 331—ab
ear pressure pain, [Rosenfeld] 252—ab
epidemic, [Auricchio] 2089—ab
epidemic and tuberculous, [Stransky] 666—ab
experimental purulent, [Kasahara] 2078—ab
herpetic, [Philibert] 503—ab
influenza, [Schmidt & Weinberg] 665—ab
meningeal reactions in children, [Stooss] 1405—ab
meningococcus, [González Alvarez] 426—ab
meningococcus epidemic, antiserum treatment of, [Lewkowicz] 1821—ab
pneumococcus, protracted, [Portu Pereyra] 2090—ab
purulent, [Hauke] 1574—ab
serous, in children, [Casaubón] 1738—ab
serous, in infants from lead poisoning, [Suzuki & Kaneko] 1819—ab
serous, labyrinth sign of, [Ferreri] 828—ab
syphilitic, [Turner] 1080—ab, [Sully Périssé]
syphilitic, after arsenicals, [Roch] 1482—ab
tuberculous, among children, [Kaneko] 501—ab
tuberculous, experimental, [Kasahara] 2078—ab
tuberculous, simulating encephalitis, [Bernstein] *1915
tuberculous, urinary disturbances in, [Czyhlarz & Pick] 1007—ab
MENINGOCOCCI, cultural characteristics of, [Atkin] 500—ab
fatal anaphylaxis following intravenous injection of antimeningococcic serum, [Mendeloff] *1862
MENINGO-ENCEPHALITIS, gummatous, [Clanuli] 663—ab
in apparently normal laboratory animals, [Cowdry & Nicholson] *545
MENOPAUSE and fibroids, [Graff] 1308—ab
MENORRHAGIA, blood during treatment of, [Kiehne] 344—ab
irradiation of spleen in, [Sahler] 1743—ab
radium therapy for, [Varley] 1150—ab
treatment by anaphylactic shock, [Slivinski] 1482—ab
MENSTRUATION and corpus luteum, [Cotte] 662—ab
and ovaries, [Ramirez] 1647—ab
and pregnancy in lymphadenoma, [Gemmell] 246—ab
MENSTRUATION, anomalies of, [Fekete] 588—ab
changes in oviduct during, [Snyder] 2082—ab
disturbed, roentgenotherapy in, [Rongy] 1144—ab
effect of placenta extract on, [Jacoby] 158—ab
influence of pituitary body on corpus luteum and, [Hofbauer] 1009—ab
menstrual crisis, [Guillaume & Godel] 1573—ab
no influence of corpus luteum on, [Schickelé] 1304—ab
sugar metabolism during, [Heilig] 1740—ab
toxin of, study of, [Macht & Lubin] 1079—ab
vicarious, [Keitler] 344—ab
MENTAL DISEASE: See also Dementia Praecox; Feeblemindedness; Insanity; Psychoses
MENTAL DISEASE, analysis of 700 cases of, by a state hospital in the field, [Jackson & Pike] *1098
etiologic factors in mental breakdowns, [Brawner & Brawner] 1812—ab
gastro-intestinal conditions associated with, [Henry] 2145—ab
rôle of nutrition in, [Richardson] 60—ab
sedimentation of erythrocytes in, [Glaus] 1403—ab
MENTAL HEALING, some press-agent work for alleged text book, 1063—P
MERCHANTS PROTECTIVE AGENCY, INC., [Owen] 1630—C
MERCURIC CHLORID, antidote to, [Rakusin & Nesmejanow] 344—ab
enhancing action of, [Joachimoglu] 666—ab
nephrosis, [Stukowski] 427—ab
poisoning, treatment of, [Weiss] 1077—ab
MERCUROCHROME, effect of, on bacteriostatic action of blood, [Hill & Colston] 157—ab
intravenously, in septicemia and local infections, [Young & Hill] *669
intravenously, in tuberculous sinus, stomatitis following, [Guy] *2110
intravenously, salivation due to, [Bunten] *1443
MERCURY: See also Mercuric Chlorid
MERCURY, acute nephritis from, in infant, [Beretervide & Romero] 251—ab
mercurial eruption, [Hoffert] 1824—ab
poisoning and abortion, 1286
MESENTERY, cicatricial mesenteritis, [Caravan] 425—ab
cysts of, in children, [de Pena] 2089—ab
METABOLIN, [Vahlen] 70—ab
and pancreas, [Vahlen] 831—ab
METABOLISM: See also Carbohydrate metabolism; Nitrogen metabolism; etc.
METABOLISM, basal, and drugs, 393—E
basal, and thyroid activity, 569
basal, and thermal environment, 1785—E
basal, effect of small breakfast on energy metabolism, [Bauer & Blunt] 1225—ab
basal, energy transformation at rest and at work with high and low respiratory quotients, [Boothby & Barborka] 1990—ab
basal, in infants, [Muhl] 1234—ab
basal, in myxedema, [Jackson] 334—ab
basal, in office practice, [Haller & Clayton] 1731—ab
basal, in skin disease, [Lévy-Franckel & Juster] 826—ab
basal, in uncinariasis, [McBrayer] 426—ab
basal, increased, and hypertension, [Mannaberg] 756—ab
basal, proportional metabolism in undernourishment, [Möller] 1158—ab
experiments on rats, [Jansen & Donath] 1828—ab
factors affecting, [Hoffman] 1000—ab
graphic registration of, [de Barenne & Burger] 1233—ab
inadequacy of measured diet as index of food metabolized, [Richardson] 156—ab
mineral, and iontherapy, 2064
numerical factors in, [Michaelis] 1224—ab
METAPSYCHICS, [Richet] 249—ab
METATARSUS disease, Deutschländer, [Koch] 990—ab
METEORISM, fermentative, [Hayem] 163—ab
METEOROLOGY and medicine, 1445—E
METHYL ALCOHOL, Schiff's reagent for detection of, 228
METRORRHAGIA: See Uterus hemorrhage
METZ, A., and the human eye, [Ball] 324—C
MICROCOCCUS catarrhalis, meningitis due to, [Garland] 331—ab
melitensis, agglutination of Malta fever cocci in tuberculosis, [Amabile] 1305—ab
melitensis, goat carriers of, [Burnet & Anderson] 2087—ab
pharyngitidis-siccae, kidney infection due to, [Kretschmer & Hufnagel] *1850
MICROSCOPY, cuscope as an aid to, [Exton] *1838
MIDDLESEX COLLEGE of Medicine and Surgery, Cambridge, Mass., 1067
MIGRAINE, calcium lactate for, [Bigland] 337—ab
duodenal, [Duval & Roux] 1303—ab
parenteral peptone therapy in, [Herrera Vegas] 166—ab
periarterial sympathectomy in, [Hellwig] 1086—ab

MIGRAINE, psychic manifestations of, [Moersch] 2145—ab
surgery for, results of, [Buchanan] 2146—ab
with hypertension, [Thaysen] 430—ab
MILK, acidified with lemon juice, [Hess & Matzner] ★1604
action of insulin on, [Giusti & Rietti] 1083—ab
aerobic spore bearing bacteria in, [Lisk] 747—ab
allergy, acne due to, [Hoge] ★788
arsenic in, after arsphenamin intravenously, [Fordyce & others] 1075—ab
bacillus acidophilus therapy, [Kopeloff] 655—ab, [Kopeloff & Beerman] 655—ab, 1696—E
bacillus acidophilus, production of, on large scale for general use, [Bass] ★1593
catalytic action of minute amounts of copper in destruction of antiscorbutic vitamin in, [Hess & Weinstock] ★952
condensed, as antiscorbutic, [Lesné & Baruk] 1303—ab
consumption of, in the United States, 2121—E
dried, regulations for sale of, 642
drinking or sipping, 1801
frozen, and acidosis, 1139
goat's milk anemia, [Brouwer] 71—ab
hemolytic streptococcus of human origin in, [Beckwith & Eddie] 1225—ab
in Infant Feeding: See under Infants feeding
Injections: See Protein therapy; and under names of various diseases
milk is essential, [Bloch] 917—ab
mother's, calcium content of, [deBuys & Von Meysenbug] 2078—ab
mother's, effect of inadequate diet on, [Courtney] 331—ab
mother's, poison of Amanita in, [Buttenwieser & Bodenheimer] 2091—ab
pasteurization of, and dysentery, 1211
preferential milk tickets in France, 644
sale of, 807
Secretion: See Lactation
sour, streptococci of, [Ayers & others] 498—ab
vitamins in, and food of cows, [Eckstein & Rominger] 1659—ab
MIND, personality of the patient, [Roberts] 1389—ab
MINERAL WATERS, Capon Springs Water, [Hare] 1138—C
results of Moureu expedition, 47
Second Spanish Congress on Medical Hydrology, 1877
MINERS, ancylostomiasis in, 1135
vital capacity of, 1976—ab
MINES, accidents in, 1466
preliminary report on sanitation in, 572
MINUTE MATERIALS, possible potencies of, 307—E
MITES in human feces, [Westphalen] 1007—ab
MITOCHONDRIA, [Wallin] 819—ab
and precollagen fibrils, [Laguesse] 1573—ab
are bacteria, [Wallin] 1570—ab
MITRAL VALVE, insufficiency, [Barry] 1301—ab
stenosis, congenital, with hypoplasia of left ventricle and left auricle; rudimentary aorta and other developmental defects, [Donnally] ★1318
stenosis, left auricle in, [Mentl] 1904—ab
stenosis, paralysis of recurrent laryngeal nerve in, [Notkin] 655—ab
stenosis, pressure of full bath in, [Lurz] 930—ab
MOLE, enormous, pigmented, [Quigley] ★2029
MONEY, dirty, bacterial aspects of, 548—E
MONGOLISM: See under Idiocy
MONOCYTE reaction, [Kohn] 170—ab
MONOPLEGIA, crural, due to vascular lesion, [Wilson] 333—ab
MONSTERS, umbilicocephalopagus, rare double monster, [Krause] 1234—ab
MONTAGUE'S PETROLEUM EMULSION with hypophosphites, 989—P
MONUMENT to medical heroes, 1375
MORPHIN, morphinism, [Wuth] 73—ab
evidence of intent in dispensing, 2076—MI
poisoning, caffein in, [Haskell & others] 1296—ab
skin reaction to, [Pilcher & Sollmann] 1729—ab
susceptibility of suprarenalectomized rats to, [Scott] 61—ab
unregistered physician in possession of, 574—MI
MORRIS, MALCOLM, memorial to, 1874
MORTALITY STATISTICS: See Infants mortality; Maternal mortality; Vital Statistics
MOSQUITO control, empiricism in, 1448—E
extermination, fish as antimosquito agencies, [Molloy] 1392—ab
larvae, effect of oil on, 798—E
ludlowi mosquito, [Ter Poorten] 1828—ab
MOSSY FOOT in Peru, [Rojas] 663—ab
MOTHER and child, biologic oneness of, [Mayer] 344—ab
MOTION PICTURES, epidemic of mystic ideas of sacrifice from, [de Massary & Rachet] 423—ab
Spanish scientific film, 1377
MOTION PICTURES, use of, for dental instruction, 806
who invented moving pictures? 1280
MOUNTAIN SICKNESS, causes of, 1794
MOUREU expedition, results of, 47
MOUTH, melanoplakia of, [Reiche] 1088—ab
MRÁZEK, death of, 224
MUCOUS MEMBRANE, normal, spirochetes penetrate, [Brown & Pearce] 1992—ab
MUMMIES and medicine, 643
MUMPS: See Parotitis
MURDER, death from lack of medical treatment no defense against charge of homicide, 154—ML
MUSCLE, atrophy of, prophylaxis of, [Mandl] 1657—ab
action and volume of, [Schultze] 1903—ab
after insulin and fasting, [Kuhn & Baur] 1999—ab
cerebellum in relation to muscular action, [Leiri] 832—ab
contraction, processes involved in muscular activity, [Hartree & Hill] 660—ab
contraction, synergy and chronaxy, [Bourguignon] 584—ab
contracture and lactic acid, [Meyerhof] 1233—ab
extract, action of, on muscular work, [De Vaucleroy] 1230—ab
fiber, laceration of, [Pels Leusden] 73—ab
fibers, abdominal, laceration of, [Wildegans] 344—ab
hyperneurotization of, [Stookey] 918—ab
mechanism of muscular action, [Tiegs] 1733—ab
murmur, [Gray] 1882—C
striated, in polarized light, [Nageotte] 1821—ab
tonus, uniform reaction of nonstriated muscles, [Gauter] 1156—ab
weakness, study of, in infant, [Brereton & Cameron] 156—ab
MUSHROOM poisoning, [Maguire] 501—ab
poison of Amanita in breast milk, [Buttenwieser & Bodenheimer] 2091—ab
MUSTARD GAS, inner history of production of, 45
MYCETOMA, [Salvador Peralta Lagos] 587—ab
third case of, [Papenheimer] ★1692
MYELITIS, acute syphilitic transverse, [Cole] 1076—ab
funicular, [Castex & others] 504—ab
MYELOMA, anisotropic fat in, [Dyke] 824—ab
multiple, [Walker] 577—ab
myelomatosis, [Levison & Flemming-Möller] 832—ab
of alveolus after trauma, [Kittel] 1897—ab
MYIASIS, intestinal; Fannia scalaris, [Nicholls] 747—ab
MYOMA, malignant, of colon, [Scott] 498—ab
Uterine: See Uterus, myoma
MYOPIA and heredity, [Paderstein] 70—ab
MYOSITIS, infectious, [Avoni] 504—ab
ossificans, progressive, [Mackinnon] 1817—ab
MYOTONIA, atrophic, [Henner] 1157—ab
congenita, [Weiss & Kennedy] 1815—ab
MYXEDEMA, basal metabolism in, [Jackson] 334—ab
in children, [Nobel] 1659—ab
of larynx, [Josephson] ★108
tendon reflexes in, a valuable aid in diagnosis, [Chaney] ★2013

N

NAGA SORE: See Ulcers, tropical
NARCOSIS and phosphates, [Spiro] 168—ab
NARCOTICS: See also Drugs, addicts; Harrison Act, and under names of drugs
NARCOTICS, dispensing, 1059
report on, 414—ME
survey of narcotic problem, [Simon] ★675
NASOPHARYNX, fibromas in, [Alonso] 68—ab
mechanism of absorption from, [Blumgart] 1729—ab
penetrability of, 1785—E
NATIONAL RESEARCH COUNCIL, medical fellows of, 229, 1791
NAUSEA, danger in, 1222—MI
NAVY recruits, young, 1280
surgeon-general's report of, 44
NECK, "cutis striata," [Hjärne] 1158—ab
fistulae and cyst of, [Lipshutz] 1645—ab
NECROPSIES and clinical diagnosis, [Thompson] 923—ab
findings in fundus oculi, [Bulmer] 1301—ab
percentage in relation to hospital professional efficiency, [Hektoen] ★949
NEEDLES, broken, and malpractice, 1805
NEGLIGENCE, no competent evidence of, 1806—MI
impunity to operating surgeons, 2143—MI
NEGRO, incidence of heart disease in, [Woody] 1149—ab
medical school for, in South Africa, 314
NEISSER-WECHSBERG PHENOMENON, [Joannides] 1828—ab
NEOARSPHENAMIN: See also Arsphenamin
NEOARSPHENAMIN, danger of, in syphilitics with malaria, [Marinesco & Draganescu] 423—ab
in surgical infections, [Biri] 757—ab
intraperitoneal administration of, [Rosenberg] ★682
NEOARSPHENAMINE-MALLINCKRODT, 1443
NEOCINCHOPHEN in rheumatic fever, [Boots & Miller] ★1028
NEPHRECTOMY based on Ambard formula, [Teposu] 1822—ab
NEPHRITIS, acidity of urine in, [Kempmann & Menschel] 830—ab
acute mercurial, in infant, [Beretervide & Pozzo] 251—ab
alimentary glycosuria in, [Heténýi] 1234—ab
blood in, [Salvesen & Linder] 578—ab
chronic, with high blood pressure, [Barbosa] 504—ab
clinical varieties of [Monro] 1082—ab
cure of, by pneumonia, [Giugni] 2089—ab
diagnosis of type of, [Bloch & Einstein] 931—ab
from rhinopharyngeal foci, [Laemmer & Tarneaud] 752—ab
hemorrhagic, [O'Hare & Walker] 1144—ab
hippuric acid in, [Snapper & Grünbaum] 665—ab
in epidemic encephalitis; difficulty in diagnosis from mycloclonic uremia, [Bennett] ★957
intradermal salt solution test in, [Aldrich & McClure] ★1425
malignant hypertension nephritis, [Schwarz] 1223—ab
of children, eclampsia in, [Nobécourt] 1153—ab
persistent pregnancy nephritis, [Schilling & Gröbel] 1901—ab
renal efficiency tests in, [Crawford] 1082—ab
surgical treatment of, [Gmelin] 1157—ab
thyroid treatment of, [Campanacci] 1309—ab
NEPHROROSEIN, [Krukowsky] 585—ab
NERVE anastomosis for recurrent laryngeal paralysis, [Frazier] 1145—ab
auditory, malaria treatment of syphilis of, [Krassnig] 666—ab
Blocking: See under Anesthesia
cranial, paralysis of last four, [Hennebert] 586—ab
injuries and neuro-arthropathies, [Philips & Rosenheck] ★27
median, pattern of weakness of hand in lesions of, [Pollock] 1300—ab
periarterial, physiology of, [Dennig] 1902—ab
Pneumogastric: See Nerve, vagus
Renal: See Kidney, pain
Sciatic: See Sciatica
spinal, clinical effects of rhizotomy, [Shaw] 2085—ab
spinal, clinical importance of recurrent branch of [Leriche] 2088—ab
spinal, intervertebral compression of, 34—E
spinal, syphilitic radiculitis, [Clark] 504—ab
superior laryngeal, neuraligia of, [Halphen] 1152—ab
surgery, omentum wrapping for nerve, [Linberg] 1657—ab
trigeminal, physiology of, [Brandão] 587—ab
ulnar, pattern of weakness of hand in lesions of, [Pollock] 1300—ab
vagus, and cervical sympathetic, communication between, [Shawe] 1480—ab
vagus, dyspnea in vagus compression test, [Recht] 2149—ab
vagus studies, [Henrijean & Waucomont] 1653—ab
NERVOUS SYSTEM, diseases, specificity of streptococci in etiology of, [Rosenow] ★449, 1988—ab
neuropathic diathesis, types of, [Pototzky] 1008—ab
sympathetic, and baldness, [Saalfeld] 2150—ab
sympathetic, and heart, [Babcock] 820—ab
sympathetic, cervical, communication with vagus, [Shawe] 1480—ab
sympathetic, coordination of functions of, [Mayo] 1299—ab
sympathetic, disturbances of, [Dresel] 1088—ab
sympathetic, ganglioneuroma of cervical and thoracic sympathetic ganglions, [Stout] ★1770
sympathetic, pathologic anatomy of, [Laignel-Lavastine] 1006—ab
sympathetic, permeability and sympathetic innervation, [Asher & others] 2092—ab
Syphilis: See Neurosyphilis
tumors of, and Wassermann reaction, [Weil & Weismann-Netter] 248—ab
Vegetative: See Nervous System, sympathetic
NETHERLANDS Society for Study of History of Medicine, Physics and Mathematics, [van Leersum] 253—ab
NEURALGIA, ascending, of traumatic origin, [Leriche & Wertheimer] 1655—ab
in arm, [Fischer] 342—ab
trigeminal, [Pinard] 423—ab
trigeminal, gasserectomy for tic douloureux, [Coughlin] 1818—ab
trigeminal, major, [Flynn] 1650—ab
trigeminal, major, unique symptom observed but once in 760 cases of, [Frazier] ★302
NEURASTHENIA and tuberculosis, [Tardieu] 1654—ab
traumatic, [Buzzard] 338—ab, [Reynolds] 500—ab

NEURITIS, brachial pressure, [Mercer] 421—ab
multiple, after carbon monoxid poisoning, [Wilson & Winkleman] *1407
multiple, erythredema, [Paterson & Greenfield] 66—ab
optic, acute axial, [Demaria] 754—ab
optic, acute retrobulbar, [de Andrade] 928—ab
optic, tonsillectomy in, [Poppi] 828—ab
retrobulbar, and accessory sinus disease, 2063
syphilitic polyneuritis, [Cardoso Fonte] 1900—ab
NEUROFIBROMATOSIS: See Recklinghausen's Disease
NEUROLOGY in France in 1923, [Laignel-Lavastine 1304—ab
NEUROMA explains failure to recover after removal of semilunar cartilage, [Dunn] 1816—ab
nasal, [Riccitelli & Franchini] 166—ab
neuroses, coordination of human vegetative functions, [Mayo] 1299—ab
NEUROSYPHILIS and heredity, [Husler] 1234—ab
and malaria, [Bercovitz] 1713—C
and syphilis of aorta, [Löwenberg] 1653—ab
bismuth in, [Seethre] 1090—ab
colloidal benzoin reaction in, [Hicks & Pearce] 1081—ab
experimental, [Plaut & others] 344—ab
NEVUS: See Angioma
NICOTIN: See Tobacco
NIPPLE, Paget's disease of, [Cheatle] 64—ab, [Bloodgood] 1223—ab
symmetrical necrosis of, in puerperium, [Katz] 1235—ab
NITRITE, sodium, effect on blood pressure; urinary response, [Mason] 2083—ab
NITRITOID reaction, 148
NITROGEN, excretion of ammonia and, [Hubbard] 929—ab
metabolism, effect of iodids on, [Grabfield & others] 656—ab
metabolism in renal tuberculosis, [Agrifogtio] 1900—ab
NITROGLYCERIN, action of [Grossmann & Sandor] 71—ab
NIYOGNIYOGAN as anthelmintic, [Guerrero] 1894—ab
NOMENCLATURE, opinions on, [Stiles] 990—C
NOSE, accessory sinuses, asthma and infections of, [Heatly & Crowe] 334—ab
accessory sinus disease and retrobulbar neuritis 2063
accessory sinuses, blindness from sinusitis, [Demaria] 1823—ab
accessory sinuses, and results in operations of, [Lawmill] 1389—ab
choanal obstruction of, [Halphen] 927—ab
diphtheria obstruction of, [O'Reilly] *631
double, 977—ab
fibroglioma of root, [Rocher & Anglade] 1655—ab
gangrene in, complicating diabetes mellitus, [Bowers] *1325
hemorrhage, an expedient to control, [Levine] *206, [Sonnenschein] 411—C, [Johnson] 411—C, [Waring], 411—C
larvae in, [Gurria Urgell] 2148—ab
NOSTRUMS, inconsiderate use of new drugs, 222
NUCLEUS RUBER, red nucleus and posture, [Magnus & Rademaker] 663—ab
NUGA-TONE, 1628—P
another death from, [Cauthorn] 1883—C
NURSES, government classification, Board fixes salaries for, 483
bill to retire nurses reported favorably, 1792
monument to, 1210
NURSING, trend in medical and nursing services, [Pusey] 1960
NUTRITION disturbances, fluid in, [de Capite] 249—ab, 1006—ab
disturbances, proportional metabolism in, [Möller] 1158—ab
erroneous ideas on, [de Groot] 1010—ab
methods of determining malnutrition in children, [Garrahan & Bettinotti] 2089—ab
mother's nutrition and fetus, [Hillejan] 829—ab
rôle of, in mental disorders, [Richardson] 60—ab
use and abuse of weight-height-age tables as indexes of, [Baldwin] *1
NYSTAGMUS, miners' 550—E
tests: See under Vestibular apparatus

O

OBESITY: See also Adiposis dolorosa
OBESITY and heredity, 476—E
another "fat cure" nostrum exploited to medical profession and public, (Citrophan) 734—P
blood and plasma volume in, [Brown & Keith] 1077—ab
parasitism of fat, [Beall] 1993—ab
studies on metabolism of, [Strouse & others] 1989—ab, *2111
treatment of hypertension and, [Weller] 929—ab
treatment of, principles involved in, [McLester] *2103
OBSERVATIONS, when one may testify as to, 1142—MI
OBSESSION of thought-theft, [D'Allones]
OBSTETRICS: See also Labor; Maternal mortality
OBSTETRICS, medals and tokens illustrative of [Mastin] 1010—ab
is obstetrics major or minor surgery? 1802
obstetric rectal examination, [Theodor] 2000—ab
plea for a more scientific and humanitarian consideration of lying-in patient, [Lynn] 1472—ab
Prussian, in 17th century, [Clemens] 1217—C
statistics, [Franke] 505—ab
OCCIPITAL BONE, abscess, mastoid disease with, [Anderson] 247—ab
OCULOCARDIAC REFLEX: See under Reflexes
OIDIUM albicans, thrush fungus and gastric ulcer, [Merke] 1484—ab
OILS, antirachitic effect of, [Shipley & others] 1225—ab
OLD AGE: See also Longevity
OLD AGE, senile brain, [Foix & Nicolesco] 249—ab
selective effect of food scarcity on aged persons, 1879
OLECRANON, fracture of, [Robertson] 1062—ab
OLEOTHORAX and spontaneous pneumothorax, [Emile-Weil & others] 164—ab
OLIVE OIL, absorption of, in infants, [Frontali] 1506—ab
OMENTUM, rôle of, in antibody production, [Portis] 1078—ab
OMPHALOMESENTERIC DUCT, prolapse of intestine through, [Cutler] 2081—ab
OPHTHALMIA; vitamin in garden soil, [McCarrison] 161—ab
OPHTHALMOLOGY, history, Thomas Young (1773-1829), physician and scientist, [Hooker] *855
OPIUM, action of, on plain muscle, [Ganter] 1741—ab
ORBIT, plastic repair of depressed fracture of lower orbital rim, [Goldthwaite] *628
epithelioma of, [Heitor Fraguer Frões] 1823—ab
lymphoma of, radiotherapy in, [Tiscornia] 1306—ab
ORCHITIS, lead, report of case, [McCord & Minster] *1104
orchiepididymitis after antimeningococcus serum treatment, [Guinon & Lamy] 1401—ab
ORGANOTHERAPY: See also Endocrines; Pituitary Body extract; etc.
ORGANOTHERAPY, [Brown] 245—ab
future of, [Sansum & Blatherwick] 418—ab
limitations of, 1048—E
plurigiandular, fallacy of, 963—ab
ORGANS, fields without vessels, [Melnikoff] 71—ab
survival of transplanted organs, 393—E
ORIENTAL SORE: See Leishmaniasis cutaneous
ORIENTATION, disturbance of, [Herrmann] 666—ab
ORPHANS of physicians in Spain, asylum for, 43
ORRIS-ROOT, powdered, conjunctivitis from, [Roy] *208
ORTHOPEDICS, orthopedic service in Boston, 48
orthopedic preventive medicine, [Thomas] *2095
OS COCCYGIS: See Coccyx
OSMOSIS, regulation of, and nervous system, [Jungmann & Bernhardt] 1089—ab
OSTEITIS, chronic sclerosing, [Henderson] 238—ab, [Henderson] *945
deformans, mono-osteitic type of, [Newton] 822—ab
deformans of skull, [Swift] 1299—ab
metastatic, [Gejrot] 589—ab
multiple, in pneumonia, [Armand Ugón] 1085—ab
OSTEOCHONDRITIS, 986
and endocrine derangement, [Lieschied & Sellheim] 2092—ab
deformans juvenilis, of hip joint, [Perthes] 1658—ab
deformans juvenilis, infection cause of, [McWhorter] 2146—ab
OSTEOMALACIA, initial stages of, [Burckhardt-Socin] 505—ab
OSTEOMYELITIS, acute, of vertebrae, [Mathieu] 1084—ab
acute septic, [Hedlund] 2000—ab
diagnosis, treatment, biased judgment, damages, 654—MI
localized, silent foci of, [Phemister] *1311
vaccine therapy in, [Rovsing] 74—ab
OSTEOPSATHYROSIS, idiopathic, [Rodriguez] 1816—ab
OTITIS MEDIA, subjective disturbances in head of otitic origin, [Salazar] 1149—ab
scarlet fever otitis, [Harries & Gilhespy] 1820—ab
zinc ion therapy, [Schmidt] 254—ab
OTOLITHIC APPARATUS: See under Ear
OTOSCLEROSIS, development of, during pregnacy, [Burger] 668—ab
treatment of, [Higier] 1575—ab
OVARIAN RESIDUE-LEDERLE, 391
OVARY, cyst, intestinal obstruction caused by, [Wakeley] 825—ab
cyst, large, [Motley] 1149—ab
cyst, complicating pregnancy, [Kickham] 1729—ab
cystadenomas, origin of, 395—E
disease of ovaries, [Bento de Lemos] 928—ab
disturbance of, corneal herpes from, [Niedermeyer] 2091—ab
endometrial tissue in, [Schwarz & Crossen] 2079—ab
function, relation of endometrium to, [Norris & Vogt] 657—ab
grafting, pregnancy after, [Sippel] 667—ab
grafts of, preserves function, [Estes] 1300—ab
histology of, in fibroids, [Mazal & Bocek] 1010—ab
hypernephroma of, in child, [Downes & Knox] *1315
implantation, modification of race characters, [Pézard & others] 2000—ab
irradiation of, effect on offspring, [Unterberger] 344—ab
physiology, so-called puberty gland, [Benthin] 1007—ab
tumors, solid tumors of ovary, [Geist] 2079—ab
OVULATION, midpains, [Stratz] 2094—ab
OVUM, viability of, [Hartman] 819—ab
OXECEPHALY: See Cranium, sutures
OXIDAZE TABLETS, 989—P
OXYGEN inhalation and hyperglycemia, [Pinali] 425—ab
inhalation of, in surgery, [Panis] 2088—ab
oxygen test of thyroid tissue, [Hara] 169—ab
OXYURIS, development of, [Wundt] 1999—ab
OZENA, diphtheria and atrophic rhinitis, [Kawano] 253—ab

P

PACHYMENINGITIS interna, spinal puncture in, [Fried] 748—ab
suffocation by, 550, [Balthazard & Duvin] 661—ab
PAGET'S DISEASE of female nipple, [Cheatle] 64—ab, [Bloodgood] 1223—ab
PAIN in serous membranes and its value in diagnosis, [Cappa] 1642—ab
abdominal, [Brüning] 1901—ab
abdominal, pyelography aid in diagnosis of, [Fuller] 1897—ab
referred, further studies of viscerosensory phenomena; acute cholelithiasis; acute nephrolithiasis, [Livingston] 1495, 1985
referred, produced at different points in esophagus, duodenum and proximal jejunum, [Jones & others] 2078—ab
subdiaphragmatic, of cardiac origin, [Billings] 156—ab
umbilical colic, [Metis] 506—ab
"PAINODYNES," 1632
PALATE, cleft, and hare lip, [Baird] 1390—ab
soft, sarcoma of, in child, [Cholsser] 1894—ab
PALPATION and percussion, ambidextrous, [Webb] *944
PANCREAS, accessory, [Hedry] 427—ab
acute necrosis of, differential diagnosis of, [Bringmann] 2148—ab
and carbohydrate metabolism, [Toenniessen] 990—ab
and diabetic metabolism, [Oertel] 1652—ab
cancer of, [Ward & Chaney] 1810—ab
disease, diagnosis of, [Simon] 1826—ab
effects of carbohydrate deprivation of function of [Southwood] 247—ab
function of, [McClure & others] 1991—ab
function of, in achylia gastrica, [McClure & others] 1146—ab
internal secretion of, 1625
toxic and active fractions in, [Fisher] 331—ab
tumor of, malignant [Foot & others] 745—ab
PANCREATIC DUCTS, reflux of bile up duct of Wirsung caused by impacted biliary calculus [Cameron & Noble] *1410
PANCREATITIS, [Smead] 1728—ab
acute, [Waring & Griffiths] 923—ab, [Vogel] 2092—ab
acute, following gestation, [Baker] 1812—ab
acute hemorrhagic, [Faure & Allende] 755—ab
acute, with erosion of splenic artery and fatal hemorrhage, [Moench] *360
acute, with fat necrosis, [Oehler] 1309—ab
acute, with fat necrosis complicated by diabetic coma, [Rodrigues] *203
etiology, reflux of bile up duct of Wirsung, [Cameron & Noble] *1410
relation of gallstones to, [Fallon] 1394—ab
roundworm causes, [Gallie & Brown] 917—ab

PANEL SYSTEM, court of inquiry; favorable result for physicians, 559
inquiry into panel physicians' fee, 402, 483, 1373
neglect under, 221
struggle, in England, 46
PAPILLA OF VATER, carcinoma of, [Abell] 749—ab
PARABIOSIS in study of deficiency diseases, [Dragstedt & Cooper] 331—ab
PARACENTESIS, 1667
PARAFFINOMA of vas deferens; unusual complication of inguinal hernia, [Watson] ★1935
PARAGANGLINA VASSALE not accepted for N. N. R., 2068—P
PARALYSIS after serum treatment: See under Serum
agitans, [Critchley] 1156—ab
agitans, experimental [Mella] 1475—ab
agitans, psychic symptoms in, [Jackson and others] 333—ab
agitans, suicide in, 47
bulbar, acute, [Koster] 1744—ab
Diphtheritic: See Diphtheria
facial, diathermy of, [Bordier] 340—ab
facial, motor apparatus in, [Monrad-Krohn] 1895—ab
Infantile: See Poliomyelitis
laryngeal, in association with mitral stenosis, [Price] ★1251, [Notkin] 655—ab
laryngeal, transient postpartum, [Herold] 1406—ab
laryngeal, nerve anastomosis for, [Frazier] 1145—ab
obstetric brachial, [Boorstein] ★862
peripheral, examination of, [Froment] 164—ab
progressive, arsphenaminized serum in treatment of, [Purves-Stewart] 1479—ab
progressive, chancre in juvenile with general paralysis during antisyphilitic treatment, [Shinkle] ★1780
progressive, fever treatment of, [Mühlens] 505—ab
progressive, frequency of, [Marie & Kohen] 1898—ab
progressive, hemolysins in pathogenesis of, [Kafka] 1659—ab
progressive, in spite of malaria, [Schwartz] 2093—ab
progressive, latent period in, [Wiesel] 1660—ab
progressive, malaria treatment of, [Weygandt] 252—ab, [Plehn] 936—ab; 1279, [Grant & Silverston] 1302—ab; 1378; [Skrgaard] 1904—ab
progressive, onset of, [Lévy-Valensi] 1737—ab
progressive, presymptomatic phase of, [Claude & others] 927—ab
progressive, relation to masked malaria and epilepsy, [Redlich] 1008—ab
progressive, sodium lodid in, [Lawson] 922—ab
progressive, specific and nonspecific treatment of, [Franck] 1006—ab
progressive, treatment of [Weichbrodt] 167—ab, [Pötzl] 506—ab, [Dattner] 836—ab, [Gaehlinger] 1651—ab, [Stärcke] 1744—ab
progressive, treatment with Spirochaeta Duttoni infection, [Sagel] 1575—ab
spastic, operative treatment of, [Royle] 1082—ab
spastic paraplegia in malignant lymphomatosis, [Weber] 66—ab
spastic, treatment of, [Silfverskiöld] 589—ab
treatment, direct neurotization of paralyzed muscles, [Serra] 1738—ab
ulnar, late, [Miller] 658—ab
PARAPHENYLENDIAMIN, detection of 739
PARASITOLOGY, animal, 1364—E
PARATHYROIDECTOMY, effect of, on development, [Hammett] 334—ab
nonprotein nitrogen in blood after, [Haden & Orr] 745—ab
PARATHYROIDS, accessory, [Shapiro & Jaffe] 418—ab
cancer metastasis in, [Dieterich] 1740—ab
conserving, in surgical operations, [Dunhill] 659—ab
dysfunction, calcium deficiency in sprue due to, [Scott] 337—ab
implantation of, from horse in treatment of postoperative tetany, [Krecke] 757—ab
Parathyroid Tablets-Armour, 1/10 grain, 1265
therapy with, 1286
PARATYPHOID and milk, [Djörup] 1576—ab
B epidemic, [Amary de Medeiros— 1900—ab
bacillus, food infection due to, [Salthe & Krumwiede] 745—ab
carrier, outbreak of food poisoning near Vienna, 1708
N, surgical importance of, [Hesse] 1575—ab
overlooked, 986
PARIS, lodgings for students, 1059
PARKINSONIAN SYNDROME: See under Encephalitis; Paralysis agitans
PARONYCHIA, Morvan's disease, [Achard] 503—ab
PAROTID, adenosarcoma of, [Porter & Churchill] 1300—ab
PAROTITIS, mumps, polyneuritis and orchitis, [Troise & Cruciani] 1154—ab
sympathetic tonus in mumps, [Benard] 163—ab
typhoid, [Jáureguy] 68—ab
PARTHENOGENESIS, traumatic, with desiccated sperm, [Rostand] 1398—ab
PASTEUR fund, 1211
precursors of, [van Leersum] 254—ab
PASTEURIZATION, attenuation of bacteria by, [Allen] 242—ab
PATCH'S FLAVORED COD LIVER OIL, 717
PATELLA, dislocated, 2 rare cases of, [Scott] ★1198
slipping, new operation for, [Soutter] ★1261
PATELLAPEXY, [Stern] 1817—ab
PATENTS, Chemical Foundation wins, 130—E
PECTORILIQUY, aphonic, [Pari] 1483—ab
PEDICULOSIS, nodding spasm in infant, [Baltasar Hernández Briz] 1232—ab
PÉLISSIER, life sketch of, 1280
PELLAGRA, conquest of, 305—E
PELVIMETRY, roentgenographic, [MacKenzie] 64—ab
PELVIS, contracted, [Fitzgibbon] 1001—ab, 1081—ab
infections, treatment of, [Sellers] 1227—ab
narrow, diagnosis of, [Rubeska] 1010—ab
pathology of infundibulopelvic ligament, [Solleri] 341—ab
shoulder pain with pathologic processes in, [Cederberg] 1310—ab
PEMPHIGUS vulgaris with spinal cord changes, [Covey] 1393—ab
PENIS, reflex trophy and contracture of, following herniorrhaphy, [Wilson] ★1667
sarcoma of, primary sarcoma of penis, [Joelson] 1001—ab
PENSIONS improved conditions for pensioners, 1373
physicians' inheritance of, 1624
PENTOSURIA ESSENTIALIS in man, [Kofoid & Swezy] 918—ab
PEPSIN in stomach content, [Rasmussen] 758—ab
PEPTIC ULCER, [Carmichael] 1469—ab, [González Mármol] 664—ab, [Sherren] 1229—ab
and motility of stomach, [Bársony] 1309—ab
antacids in medical management of, [Shattuck & others] ★200
chronic treatment of, [Kovjanic] 664—ab
drawbacks of gastro-enterostomy, [Ohly] 1155—ab
duodenal, [Alessandrini] 166—ab
duodenal, and life insurance, [Forsyth] 1995—ab
duodenal, direct visualization by means of roentgen ray, [Knapp] ★1585
duodenal, extensive resection of stomach in, [Finsterer] 346—ab
duodenal, inflammatory basis for, [Konjetzny] 1307—ab
duodenal, jaundice with, [Bickel] 230—ab
duodenal, niche in diagnosis of, [Diamond] 1813—ab
duodenal, significance of cardiac irregularities in reference to operability of, [Straus & Hamburger] ★706
duodenal, surgical end-results in, [Haggard & Floyd] 1479—ab
gastric, [Werthelmer] 1824—ab
gastric, and focal infection and arthritis, [Nakamura] 821—ab
gastric, and thrush fungus, [Merke] 1484—ab
gastric, cancer in, [Finsterer] 168—ab
gastric, capillaries of lip in, [Mayer-List] 1999—ab
gastric, experimental, [Bedarida] 1738—ab, [Dragstedt & Vaughn] 2081—ab
gastric, familial, [Ohly] 73—ab
gastric, longitudinal resection of lesser curvature, with resection of pyloric sphincter for [Strauss] ★1765
gastric, pathogenesis of, [Jarno] 1824—ab, [Mueller] 1999—ab
gastric, pathology of, [Stewart] 161—ab
gastric, social indications for, operative treatment of, [Friedemann] 1307—ab
gastric, spasmophilia in, [Perlitz & Fleischer] 1307—ab
gastric, thrombophlebitis around, [Podlaha] 429—ab
gastric, treatment of, [Pribram] 251—ab, [Bolton] 924—ab
gastrojejunal, partial gastrectomy for, [Balfour] 237—ab, 1393—ab
jejunal, [Hütten] 70—ab
jejunal alimentation in, [Bockus] ★351
jejunal, unabsorbable sutures cause, [Renton] 590—ab
juxtapyloric, [Bartrina] 342—ab
medical treatment of, without alkalis, [Frick] ★595
pain in, differential features of, [Savignac] 585—ab
pathologic anatomy of ulcer gastritis, [Kallma] 1086—ab
peptic ulcer twice, [Petersen] 1488—ab
perforated, coronary thrombosis simulating, [Hardt] ★692
PEPTIC ULCER, perforated, demonstration of spontaneous pneumoperitoneum by roentgen ray, [Copher] ★781
perforated duodenal, unusual case of, [Schurmeier] ★302
perforated gastric, treatment of, [Delore & others] 1304—ab
perforated, in girl aged 7, [Norrlin] 589—ab
results of gastro-enterostomy, [Apperly] 1820—ab
signs and pathogenesis of, [Holler] 1307—ab
studies in human constitution; clinical anthropometry, [Draper & others] ★431
surgical treatment of, [Flörcken] 427—ab, [Clairmont] 1153—ab, [Harrison] 1470—ab, [Isaac-Krieger] 1741—ab
treatment of, [Strandgaard] 2000—ab
PEPTONE: See also under names of diseases, as Migraine
PEPTONE, treatment of infections with, 1625
Witte's constituents of, [Abel & Gelling] 1298—ab
PEPTOPROTEASI not accepted for N. N. R., 2068—P
PERCUSSION and palpation, ambidextrous, [Webb] ★944
by machine, [Pohl] 2091—ab
orthopercussion, [Réval] 1743—ab
PERIARTERITIS acuta nodosa, [Ophuls] 417—ab
PERICARDITIS, pericardial friction sound disappears with change of posture, [Gordon] 1151—ab
purulent, [Edgehill & Mather] 823—ab, [Munlogurria & Zeno] 929—ab
with effusion, conduction changes with, [Gager] 1729—ab
with effusion, physical findings in, [Morris & Little] 59—ab
with effusion, pulsus paradoxus sign of, [Gauchat & Katz] 1296—ab
with effusion, therapeutic pneumopericardium in, [Oppenheimer] ★1685
PERICARDIUM, adherent, cardiolysis for, [Bourne] 825—ab
adherent, surgical treatment of, [Marvin & Harvey] ★1507
adherent, with much shriveling, pericardiectomy in, [Schmieden] 758—ab.
calcification of, case discovered roentgenologically, [Youmans & Merrill] ★1833
deficient, adult heart with, [Canavan] ★716
PERIOSTEUM, function of, in bone repair, 1694—E
PERITONEAL CAVITY: See under Abdomen; Peritoneum
PERITONEUM, drainage of, [Albrecht] 666—ab
cancer, tuberculous peritonitis and disseminated carcinoma of peritoneum, points in differential diagnosis, [Boles] ★2112
effects of chronic irritations on mesothelium of, [Cunningham] 1730—ab
unusual diverticula of, [Hill] 237—ab
PERITONITIS, cryptogenic, [Mandl] 71—ab
ether in treatment of, [Küstner] 427—ab
operations, abscess after, [Nather] 931—ab
primary, [Zierold] 1393—ab
Sgambati's reaction in [Giordano] 1154—ab, [Deutsch & Graham] 1224—ab
syphilitic, [Roorda Smit] 1236—ab, [Cardoso Fonte] 1900—ab
syphilitic, with effusion, [Mascheroni & Tourreilles] 1403—ab
tuberculous, and disseminated carcinoma of peritoneum, some points in differential diagnosis, [Boles] ★2112
tuberculous, pneumoperitoneum for, [Gilbert] 820—ab, [Mattick] 820—ab
tuberculous, traumatic, [Gerhartz] 1088—ab
with unruptured appendix, 1632, 1883
PERMEABILITY, anaphylactic capillary, quantitative study of, [Manwaring & others] ★542
and cell stimulation, [Ebbecke] 930—ab
and sympathetic innervation, [Asher & others] 2092—ab
of cells [Embden & Lange] 830—ab
PERTUSSIS: See Whooping Cough
PERTUSSIS VACCINE, 967
PESSARY, improved ball pessary, [Jacobson] ★789
intra-uterine, and extra-uterine gestation, [Kritzler] 1310—ab
PETROLAGAR, 2119
PHAGOCYTOSIS and endocrines, [Asher] 1088—ab
PHARMACISTS, bronchial asthma and other allergic manifestations in, [Peshkin] ★1854
druggists' resolution on liquors, 219
position of, in annexed parts of Roumania, 2135
PHARMACOLOGY, teaching of, [Bierring] 1071—ab
PHARMACOPEIA, oldest Swedish, [Backman] 590—ab
PHARYNGOMYCOSIS, [Davis & Hall] 1079—ab
PHENOL, discoloration from, 491
PHENOLPHTHALEIN eruptions, predelection of for Jews, [Halley] 2145—ab
PHENOLSULPHONEPHTHALEIN output, determining, [Rothberg] 336—ab
Test: See under Kidney function

PHENOLTETRACHLORPHTHALEIN, simple method for determination of, in blood serum, [Bloom & Rosenau] *547
Test: See under Liver function test
PHIMOSIS and pseudophimosis in infants, [Glass] 930—ab.
operation, cosmetic improvement of, [Sievers] 1827—ab
PHLORIZIN: See also Pregnancy, phlorizin test
PHLORIZIN, action of [Dünner] 1485—ab
PHOSPHATES and narcosis, [Spiro] 168—ab
applications of colorimetric phosphate method, [Briggs] 1816—ab
PHOSPHORUS compounds, anticoagulating, [Doyon] 926—ab
metabolism and calcium metabolism, [Telfer] 2086—ab
poisoning, [Vogt] 1479—ab
PHOTOTHERAPY, artificial light therapy in tuberculosis, [Mayer] *1920
therapeutic lamps, 2138
PHYSICAL EDUCATION and sport, 904
new bill on, 983
physiology of, [Herxheimer] 1234—ab
PHYSICAL EFFICIENCY, "duration test" of vocal sounds, [Frossard] 1481—ab
PHYSICAL EXAMINATION: See also Health examinations
PHYSICAL EXAMINATION in breach of promise case, 58—M1
PHYSICIANS: See also Medicine
PHYSICIANS and hospital, and economic organization, 1281
and housing situation in Paris, 985
and medicine, 404
and "surgeon" and "naturopath" defined—practice, 1293—M1
child moriality in families of, 635—E
crisis in medical union of Vienna, 808
criticism of younger practitioners, 1797
death of, in 1923, 34—E
employment of, for employee of corporation, 1720—M1
family, and official medical inspector, [Siredey & others] 1898—ab
fewer, 1209
foreign, influx of, 1366—E, [Bacon] 1564—C
French, in Chamber of Deputies, 1981, 2135
German, aid for, [Müller] 410—C, 732
in Belgium, fund to aid, 1135
in Belgium, number of, 1376
in Spain, social isolation of Madrid physicians, 1376
Increased influx of American physicians into Austria, 141
medical representation in Parliament, 45
Physicians' Home, Inc., 1207
proposed order of, 903
right of hospital to exclude physicians, 1805
school, new instructions for, 1136
waiver of privilege by heir also physician, MI—1637
winner of a literary competition, 1981
women, German league of, 1459
PHYSIOLOGY, endogenous activating substances, [Weichardt & Scholz] 428—ab
PHYSIOTHERAPY course at Walter Reed Hospital, 1208
organizations, 1702
PILOCARPIN, action of, on stomach, [Kalk] 1307—ab
as sudorific, 649
pharmacodynamic action of, [Cain & Oury] 165—ab
PINEAL GLAND syndromes, [Lereboullet] 239—ab
tumors of, [Brusa] 1154—ab
PIPET cleaner, new pipet cleaner, [Hartman] *1196
PITUITARY BODY, influence of, on menstruation and corpus luteum, [Hofbauer] 1009—ab
cancer, metastatic, [Piney & Coates] 1734—ab
disease, basal metabolism in, [Montes Pareja] 1573—ab
Dystrophy: See Dystrophy, adiposogenital
extract, [Turenne] 68—ab.
extract, rupture of uterus after, [Rucker & Haskell] 1232—ab
extract, standardizing, [Swanson] 1226—ab
extracts, danger of, 730
in diabetes insipidus, [Abel & Geiling] 336—ab
in pregnancy, eye changes with preeclamptic symptoms, [Mills] 1295—ab
secretion of, [Trendelenburg] 1902—ab
surgery of, [del Valle] 250—ab, [Frazier] 822—ab
syphilis of, [Jedlicka] 1235—ab
treatment and oliguria, [Molitor & Pick] 428—ab
PITUITARY TABLETS-ARMOUR, 1265
PITUITRIN: See also Pituitary Body Extract
PITUITRIN "S" (Surgical), 1265
PITYRIASIS ROSEA with particular reference to its unusual manifestations, [Klauder] *178
PLACENTA accreta, [Polak & Phelan] 1001—ab
accreta, report of case of retained placenta, clinically, placenta accreta, [Andrews] *1780
PLACENTA and motor function of uterus, [Franz] 169—ab
artificial delivery of, 48
chorio-angioma of, [Strachan] 246—ab
circumvallata, explanation of, [Lahm] 1085—ab
detached, relationship of uteroplacental apoplexy to ablatio placentae, [Holmes] 239—ab
extract, effect of, on menstruation, [Jacoby] 158—ab
extracts, [Ceresoli] 1900—ab
genesis of embryonal tissues in, [Mendéléeff] 1898—ab
placental circulation, [Fraser] 575—ab
praevia, [Liebe] 1485—ab
praevia, Braxton-Hicks version controls hemorrhage from, [Titus & Andrews] 1728—ab
praevia cases, analysis of, [Lynch] 1570—ab
praevia, treatment of, [McPherson] 1728—ab
premature separation of, [Scott] 1478—ab
regulation of "placental respiration," [Schmitt] 1235—ab
retained, epinephrin in, [Joachimovits] 2093—ab
retained, hydraulic procedure for expulsion of, [Cathala & Biancani] 1231—ab
syphilitic, [Monckeberg & Aviles] 1656—ab
turgidization of, [Heidler] 1827—ab
PLAGUE bacillus bacteriophage, [Morales Villazon] 250—ab
epidemic, another plague epidemic in India, 1622
epidemiology and treatment of, [Hivento] 165—ab
extinction of foci of, [Iglesias] 1901—ab
in Bagdad, [Heggs] 65—ab
in 1575, fight against, [Ingrao] 1305—ab
incidence of, 727
spread of, [Otten] 668—ab
transmission, and cheopis, relationship between [Cragg] 660—ab
vaccine, use of sensitized antiplague vaccines, [Stocker & Graham] 1572—ab
PLANTS, botanic survey with reference to flora responsible for hay-fever, asthma and dermatoses, [Duke & Durham] *939
protozoa of, [Franchini] 67—ab
PLASTER cast, use of—complications—liability, 1293—M1
knife, new, [Phillips] *31
PLASTIC SURGEON, breach of contract by, 1885—M1
PLEURA adhesions, diagnosis of, [Deist] 247—ab
PLEURISY: See also Empyema
PLEURISY, dry, and pleuropneumonia, [Sergent] 752—ab
at apex, [Garrahan] 69—ab
diagnosis of stage of, [Peyrer] 2093—ab
serofibrinous, treatment of, with calcium chlorid, [Burnard] 423—ab
with effusion, bacteriology of, [Graham] 577—ab
with effusion, pseudochylous, [Jankowsky] 2149—ab
with effusion, treatment of, [Lunde] 667—ab
PNEUMARTHROSIS; aid in diagnosis, [Kleinberg] 2081—ab
PNEUMOCOCCI, culture, peroxid in, [Avery & Morgan] 1148—ab
antibody solution, [Cecil & Baldwin] 1988—ab
chicken blood protects against, [Berger & Montgomery] 1818—ab
growth activity and pathogenicity of, [Bloomfield] 1888—ab
inhibition of growth of, [Robertson & others] 1147—ab
serologic types of, in pneumonia, [Webster] 1302—ab
types in Norway, [Thjötta & Hanneborg] 1893—ab
virulence of, in vegetable broth, [Picazio] 1232—ab
PNEUMOCONIOSIS, effect of carbon on tubercle bacillus, [Corper & others] 1144—ab
PNEUMONIA, blood pressure in, [Kemppmann] 1089—ab
cure, deny discovery of, [Dean & Kelley] 147—C
cure of nephritis by, [Glugni] 2089—ab
death from, after inhalation of gas, 58—M1
diagnosis of, early, [Howard] 1732—ab
diagnostic problems in, [Riesman] *1256
displacement of heart in, [Wallgren] 254—ab
experimental, blood reaction in, [Leake & others] 1396—ab
in children, interlobar reactions in, [Mouriquand & Bernheim] 752—ab
multiple osteitis in, [Armand Uzón] 1085—ab
postoperative; second communication, [Elwyn] *384
respiratory mechanism in, [Binger & Brow] 1992—ab
roentgen study of, [Paisseau & Iser-Solomon] 1083—ab
sequels of, [Southby] 2147—ab
serologic types of pneumococci in, [Webster] 1302—ab
simulating appendicitis in children, [White] *695
treatment, [Broadbent] 583—ab, [Roberts] 1811—ab
PNEUMONIA, treatment, antipneumococcus serotherapy, [Etienne & Braun] 423—ab, [Sacquépée], 424—ab
treatment, management of heart in, [Brooks] 1732—ab
treatment with pneumococcus antibody solution, [Cecil] 1640—ab
PNEUMOPERICARDIUM, therapeutic, in pericarditis with effusion, [Oppenheimer] *1885
PNEUMOPERITONEUM for tuberculous peritonitis, [Gilbert] 820—ab, [Mattick] 820—ab
as aid in diagnosis of hernia, [Farr] *1774
spontaneous, demonstration of, by roentgen ray; aid in diagnosis of acute perforating peptic ulcer, [Gopher] *781
PNEUMOTHORAX, artificial: See also under Tuberculosis, Pulmonary
artificial amaurosis from, [Izzo] 754—ab
artificial, results of, [Farrell & Fleck] 820—ab, [Morriss] 820—ab
artificial, some paradoxes of, [Piguet & Giraud] 1737—ab
concurrent, and hydropericardium, [Fox] *467
parietal valve, [Nather] 2094—ab
spontaneous, and oleothorax, [Emile-Weil & others] 164—ab
spontaneous, glucose treatment of, [Fogelberg & Wallgren] 1310—ab
PNEUMOVENTRICULOGRAPHY: See Brain, roentgenography
POISON, statistics of deaths due to, 809
POISON OAKS: See Rhus Poisoning
POISONING, antidote for arsenic, bismuth and mercury poisoning, [Semon] 1819—ab
POLIOMYELITIS, [Leone Bloise] 342—ab, [Renesse] 664—ab
and epidemic encephalitis, [Hassin] 497—ab, [Neustaedter & others] 580—ab
cephalopiegia, [Travers] 1823—ab
diagnosis of, [Sørensen] 508—ab
epidemic, [Wernstedt] 1575—ab
epidemiology of, [Schwarz] 503—ab
experimental, [Nevin & Bittman] 1648—ab
experimental, hypertonic solutions in serum treatment of, [Aycock & Amoss] 157—ab
painful form of, [Garrahan] 427—ab
pelvis in, [Laffont & Gaujoux] 662—ab
respiratory disturbances in, [Sørensen] 508—ab
roentgenotherapy of, [Phillips & Galland] *1847
specificity of streptococci in etiology of diseases of nervous system, [Rosenow] *449
treatment of, [Nobécourt & Duhem] 1304—ab
treatment, mechanical, [Platt] 1081—ab
treatment, physiologic, [Biesalski] 167—ab
virus, immunizing strain of, [Flexner & Amoss] 1992—ab
virus, revived activity of, [Flexner & Amoss] 1147—ab
POLLEN ALLERGEN SOLUTIONS-SQUIBB, 1781
POLLEN ANTIGENS-LEDERLE, 1781
POLLOSSON, AUGUSTE, death of, 807
POLYCYTHEMIA, disappearance of, and regression after virilism after removal of ovarian tumor, [Bingel] 1574—ab
symptomatic, [Morse] 1729—ab
Vaquez' disease, [Letulle & Yacoel] 1303—ab
POLYGRAPH, electric, [Waud] *1263
PORCELAIN factories, dust in, 562
PORPHYRINURIA: See under Urine
PORTAL VEIN, acute appendicitis is early pylephlebitis, [Thalhimer] 1224—ab
obliteration of, [Kuhr] 1741—ab
PORTO RICO, health of school children in, 653
POTASSIUM and sodium salts administered intravenously, [Loeser & Konwiser] 1298—ab
bioradioactivity and entropy, [Zwaardemaker] 926—ab
iodid, action of, on circulation, [Bloom] 2089—ab
Potassium Bismuth Tartrate-D. R. L. 209
salts, alleged biologic radioactivity of, 720—E
POTENCY, possible potencies of minute materials, 307—E
POWDERS, reports wanted on accidents from zinc stearate baby powders, 475
PRACTICE ACTS: See Licensure
PRAGUE, new central building for medical organizations in, 2133
PREGNANCY, Abderhalden test for, [Smith & Shipley] 819—ab
abdominal, with favorable outcome, [Brown] 819—ab
acid-base balance in plasma in, [Marrack & Boone] 160—ab
after ovary grafting, [Sippel] 667—ab
and cancer, [Odermatt] 1900—ab
and diabetes, [Lublin] 1087—ab
and gastric cancer, [Schmid] 1085—ab
and menstruation in lymphadenoma, [Gemmell] 246—ab
and Syphilis: See under Syphilis
blood chemistry during, [Stander] 2082—ab
capillary microscopy in, [Baer & Reis] *526
changes in oviduct during, [Snyder] 2082—ab
development of otosclerosis during, [Burger] 668—ab
diagnosis of, [Milnor & Fennel] *538

PREGNANCY, diet in, effect of protein-rich food, [Kaboth] 1739—ab
disturbances of, manifestations of starvation, [Opitz] 667—ab
duration of, questioned parenthood, 1631
endometriomyoma of pregnant uterus, [Lochrane] 246—ab
examination of pregnant from without, [Poeck] 1742—ab
extra-uterine, [Mason & Storrs] 242—ab, [Eeriand] 758—ab
extra-uterine, at full term, [Catlin] *107
extra-uterine, bilateral tubal, [Payne] *546
extra-uterine, ovarian, [Sutton] 819—ab
extra-uterine, transplantation of, 228
extra-uterine, ruptured, [Hermans] 1576—ab
extra-uterine, unusual tubal, [Deane & Smith] 422—ab
extra-uterine, when to operate in, [Welton] 1142—ab
extra-uterine, with intra-uterine pessary, [Kritzler] 1310—ab
heart disease in, [Schmidt] 588—ab
heart in, [Weiss] 665—ab, [Daly] *1439
hemolytic streptococci in, [Kanter & Pilot] 658—ab
herpes in, [Dexeus Font & Serra Rabert] 1306—ab
high blood pressure in, [Adair] 1397—ab
hyperthyroidism in, [Jackson] 1474—ab
influence of, on Wassermann reaction, [Browne] 924—ab
influence of thyroid on increased heat production during, [Marine] 1726—ab
inorganic salts in blood in, [Underhill & Dimick] 242—ab
interruption of, and sterilization through abdominal incision, [Rosenstein] 1742—ab
maternity and work, [Carlini] 165—ab
mercuric cyanid in, [Sauphar] 1899—ab
microscopy of blood in, [Wöhlisch & Bohnen] 1575—ab
multiple, increased frequency of, [Cristalli] 1656—ab
ovarian cyst complicating, [Kickham] 1729—ab
pernicious or hemolytic anemia of, [Rowland] *372, [Aubertin] 585—ab
persistent nephritis in, [Schilling & Gröbel] 1901—ab
phlorizin as test for, [Pérez & Brea] 505—ab, [Crainiciann & Goldenberg] 1231—ab, [Haynes] 1818—ab
pituitary in, eye changes with preeclamptic symptoms, [Mills] 1295—ab
prevention of goiter in, 1045—ab
roentgen-ray diagnosis of, [Spangler] 1391—ab
toxemia, anemia from intoxication of, [Schneider] 1742—ab
toxemia, treatment of, [Horálek] 1576—ab
toxemias, after effects of, [Harris] 1730—ab
toxemias and liver function test, [Berkeley & others] 1652—ab
toxemias, eye changes with preeclamptic symptoms, [Mills] 1295—ab
toxemias, incidence of, [Cruickshank] 924—ab
toxemias, uric acid in blood in, [King & Denis] 1728—ab
toxicoses, remote prognosis of, [Zondek & Jakovlevitz] 830—ab
unusual cases of, from Madras Maternity Hospital, [Hingston & Mudaliar] 245—ab
vagotonia as feature of, [Lourau] 597—ab
vasomotor disturbances in, [Nevermann & Framm] 755—ab
vomiting in, 902
vomiting of blood in, [Harding & Drew] 924—ab
vomiting of, insulin treatment of, [Thalhimer] *696
vomiting of, pernicious, 393—E
vomiting of, treatment of, [Castagna] 1232—ab
vomiting in, luminal sodium in treatment of, [Miller] 2084—ab
weight in, of value as test, [Davis] 240—ab
with chronic purpura hemorrhagica, [Morgan] 246—ab
PRESCRIPTION, forging name of physician to, 1386—MI
vehicles for prescriptions, 2138
PRISON inquiry, 1457
PRIVILEGED COMMUNICATIONS; expert evidence; physician may testify nonprofessionally, 818—MI
physicians' right of, 1561
statements not privileged—as to staff physicians, 1886—MI
waiver of privilege by heir also physician, MI—1637
PRIZES, additional prize essays, 1056
awarded by French Academy of Medicine, 137
awarded, cancer research, 136
British Medical Association establishes prize for general practice, 2060
contest for health posters, 1786
essays, Chemical Society, 312
for essay on military medicine, 1369
for scientific apparatus, 1791
for work on infant feeding, 1620
in therapeutics, 48
international, 340—ab
national science prizes, 1061
PRIZES of Austrian Cancer Society, 1708
of Roentgen Ray Society, 2059
Parkin, 804
physician the winner of a literary competition, 1981
Rizzoli orthopedic, 1131
to Houssay, 43
PROCAINE-ADRENALIN AMPULES 1 Cc., 1199
PROCTOSIGMOIDOSCOPE, irrigating, [Marcus] *1323
PRODIGY, brain of, 1797
PROFILOMETER, [Dahlberg] 1904—ab
PROGNOSIS, growth as factor in, "outgrowing" disease, [Holt] *1333
PROHIBITION: See also under Alcohol
PROHIBITION in United States, 138
Congress, the doctor, 2056—E
Crampton bill passed by House, 1978
movement in Belgium, 1135
new regulations, 1372
renewal of permits under National Prohibition Act, 44
results of, in Belgium, 561
transfers of permits to prescribe liquor, 1462
U. S. Supreme Court on medicinal use of malt liquors, 2054—E
validity of restrictions on prescribing alcohol, 57—MI
PROMONTA not accepted for N. N. R., 1712—P
PROSTATE, cancer, blocking lymphatics in, [Herbst] *1590
cancer and hypertrophy of, [Shaw] 999—ab
enlarged, demonstrated by air cystograms, [Ballenger & others] 1811—ab
enlarged, [Platou] 74—ab, [Hirt] 1574—ab, [Luys] 1736—ab
enlarged, demonstration of, by roentgen ray after distending bladder with air, [Ballenger & others] *1023
enlarged, radiotherapy of, [Ledoux-Lebard] 1005—ab
enlarged, roentgen-ray treatment of, [Guilbert] 1654—ab
enlarged, vasectomy with, [Stapelmohr] 667—ab
surgery of, under regional anesthesia, [Lowsley] 1644—ab
PROSTATECTOMY; analysis of cases, [Rathbun] 419—ab
factors responsible for reduction of mortality and morbidity in, [Thomas] *281
perineal, by a modified technic, [Dillon] *287
seminal vesiculitis after, [Boyd] 1300—ab
suprapubic, immediate suture of bladder after, [Merians] 1827—ab
under local anesthesia, [Jones] 1732—ab
PROSTATITIS, chronic, and lupus erythematosus, [Burke] 162—ab
gonococci not found in; effect of vaccines, [Player & others] 62—ab
PROSTITUTION in Paris, 1374
PROTARGIN strong, observations on, as a preoperative prophylactic, [Reese] *1593
PROTEIN, milk, products, feeding with, [Levy] 757—ab
Bence-Jones, precipitin reaction of, [Hektoen & Welker] 1893—ab
determination of biologic values of, [Mitchell] 920—ab
fever, [Seibert & Mendel] 332—ab, [Goebel] 1657—ab
fever and arthropathies of protein origin, [Bezancon & others] 1997—ab
injections of milk in eye diseases, [Moore] 923—ab, [de la Garza] 928—ab
injections, skin, nerves and blood, [Müller] 1156—ab
low protein diet and xerophthalmia, [Hejinian] 997—ab
Therapy: See also under names of diseases
therapy, active agent in milk injections, [Barkan & Nelson] *190
therapy, blood sugar after milk injections, [Högler] 1234—ab
therapy, history of, [Roemer] 1659—ab
therapy in acute surgical inflammatory affections, [Kaess] 1087—ab
therapy in mental disease, [Marmier] 1401—ab
therapy, nonspecific, 1883
therapy, parenteral, [Uribe Cualla] 250—ab, [Costa] 1824—ab
PROTOZOA of plants, [Franchini] 67—ab
flagellate, infestation with, 1864—E
protecting against bacilli, [Gedroyc] 1822—ab
prototoxins, [Gedroyc] 1822—ab
protozoan-like parasites in brains of apparently normal laboratory animals, [Cowdry & Nicolson] *545
PRURITUS, [Kroner] 1155—ab
diffuse, as premonitory symptom of internal cancer, [Küttner] 2094—ab
in syphilis, [Greco] 69—ab
vulvae, [Werner] 1486—ab
vulvae, injection of procain in, [Wiener] 499—ab
PSEUDOHERMAPHRODISM and suprarenal virilism, [Scabell] 2092—ab
PSEUDOSCLEROSIS, [Sahlgren] 832—ab
PSORIASIS, arthropathia psoriatica, [Garrod & Evans] 825—ab
PSYCHANALYSIS, contraindications and indications for, [Odier] 1305—ab
PSYCHANALYSIS, dangers of, in dementia praecox, [Tramer] 1482—ab
of obsessions, [Claude] 164—ab
significance of, for psychiatry, [Christoffel] 2089—ab
PSYCHIATRY, importance of, [May] 418—ab
German institute of psychiatric research, 1562
significance of psychanalysis for, [Christoffel] 2089—ab
PSYCHOLOGY in medical practice and legislation; profession's duty to itself and to the nation, [Eagleton] *2100
PSYCHONEUROSES, treatment of, [Wright] 2145—ab
PSYCHOSES: See also Insanity; Mental disease
PSYCHOSES and focal infection, [Kopeloff & Kirby] 417—ab
constitutional, ending in recovery, [Rosanoff] 497—ab
menstrual, castration in, [Ewald] 1486—ab
metabolic anomalies in, [Norvig] 1744—ab
of adolescence, prognosis of, [Henderson] 245—ab
PSYCHOTHERAPY, neurologic mistakes, [Schenk] 1999—ab
PUBERTY, paradoxic thoughts on, [Champy] 926—ab
precocious, [Hutchison & Wauthope] 1895—ab
puericulture in, [Pinard] 502—ab
PUBLIC HEALTH: See under Health
PUERPERAL INFECTION, [Turenne] 250—ab, [González] 505—ab, [Fink] 588—ab, [Rubeska] 589—ab
abdominal hysterectomy in, [Auvray] 1996—ab
and arsphenamin, [Voron & others] 1402—ab
breast nursing in, [Runge & Lauer] 2091—ab
direct local vaccine treatment of, with streptococcus filtrate, [Lévy-Solal & others] 1491—ab
gangrene of extremities complicating, [Chesky] 658—ab
lymphaticostomy in, [Edwards] 1001—ab
mortality from, [Harmon] 1295—ab
previous case, [Halford] 246—ab
treatment of, [Laker] 925—ab
treatment of, local, [Figueira de Mello] 1901—ab
treatment of, with lactic acid bacilli, [Chirié] 1899—ab
PUERPERIUM, condition of uterus postpartum, [Lankford] 1295—ab
hemoclasis and liver function in, [Rivière & Valle] 1231—ab
rupture of bladder during, [Roxas & Rustia] 1227—ab
PULMONARY TUBERCULOSIS: See Tuberculosis, pulmonary
PULSE, capillary, [Hisinger-Jägerskiöld] 932—ab, [Boas] 1896—ab, [Lewis] 1994—ab
paradoxic, nature of, [Katz & Gauchat] 1296—ab
paradoxic, sign of pericardial effusion, [Gauchat & Katz] 1296—ab
tracings, electric polygraph, [Waud] *1263
wave velocity, [Matzke & others] 332—ab
PUPIL, isolated anomalies of, as guide for treatment, [Thaysen] 758—ab
PURIN bases of urine, 1865—E
PURPURA, chronic, treatment of, [Ricaldoni & Albo] 1821—ab
hemorrhagic, [Castex & Lorenz] 663—ab
hemorrhagic, chronic, pregnancy with, [Morgan] 246—ab
hemorrhagic, splenectomy in, [Cohn] 236—ab, [Bass & Cohen] 1473—ab, [Cohn & Lemann] 2146—ab
hemorrhagic, tuberculosis in relation to, [Pratsicas] 1828—ab
Henoch's, [Kilgour] 1646—ab
Henoch's, and erythema, [Cole] 498—ab
in childhood, 1796
in twins, [Stone] 1993—ab
of urinary tract, [Praetorius] 1744—ab
PUS, violescent, bacteriology of, [Uyeno] 422—ab
PYELITIS in infants, [Leone Bloise] 753—ab
and colon bacilli meningitis, [Sickenga & Munk] 2150—ab
treatment of, 739
ureteral obstruction cause of, [Cecil] 1228—ab
PYELOGRAPHY aid in diagnosis of abdominal pain, [Fuller] 1897—ab
PYLORIC STENOSIS, complete, from carcinoma, [Swanberg] 240—ab
congenital, atropin in, [Johannessen] 932—ab
diuresis in, [Surmont & Tirpez] 248—ab
hypertrophic, [Poynton & others] 925—ab
hypertrophic, treatment of, [Bruce] 420—ab
hypertrophic, twins with, [Moore] 1398—ab
Rammstedt operation for, [Parsons] 2147—ab
PYLOROSPASM in infants, [Balan] 1656—ab
PYLORUS, exclusion of, [Silvan] 663—ab
acid reflex of, 1784—E
reflex control of, [Carlson & Litt] 1296—ab
PYOPNEUMOTHORAX, tuberculous, in infant, [Ross & Crowdy] 2079—ab
PYORRHEA ALVEOLARIS, nonspecific Wassermann reactions, 264—ab
PYOSALPINX: See Fallopian Tube

Q

QUERY ANTISYPHILITIC SERUM, 224
QUINIDIN in Heart Disease: See under Auricular Fibrillation; Heart disease; etc.
QUININ, effect of, on ear, 1802
visual by-effects of, [Bollack] 927—ab
QUINONE in cloth; detection of paraphenylendiamin, 739

R

RABIES, 813
and bovine tuberculosis in Dutch East Indies, 2133
experimental, spontaneous recovery from, [D'Aunoy] 1648—ab
in animals, 987
parasite of, [Manouelian & Viala] 1736—ab
treatment of, in Egypt, [Dolbey & Katib] 1302—ab
treatment of, modification in, [Remlinger] 1152—ab
vaccination, nervous disturbances after, [Hajek] 2000—ab
virus, efficacy of, [Harvey & Acton] 660—ab
virus, nature of, [Levaditi & others] 1996—ab
virus, single dose of, 1066
RACES, color problem in a British colony, 1058
modification of race characters, [Pézard & others] 2000—ab
racial blood grouping, [Manuila & Popoviciu] 1402—ab
RACHICENTESIS, cerebrospinal index, [Balduzzi] 1152—ab
intolerance to, [Guillain & others] 1996—ab
meningitic symptoms rapidly following and rapidly disappearing after, [Spiller & Payne] ★106
practical data on, [Cochez] 424—ab
small needle for avoiding headache from, [Blumel] ★209
RACHITIS: See also under Vitamins
RACHITIS, [Levy] 70—ab, 1211, [Haverschmidt] 2150—ab
and acidosis, [Burgess & Osman] 1003—ab
and blood calcium, [Kneschke] 72—ab
and hereditary syphilis, [Cozzolino] 2089—ab
and infection, 392—E
and nervous system, [Neurath] 1155—ab
and substances which resist saponification, [Beumer] 1008—ab
antirachitic effect of cod liver oil, [Hess & Weinstock] 575—ab
antirachitic effect of oils, [Shipley & others] 1225—ab
correction of bone curvatures in, [Rabl] 1009—ab, 1827—ab
effect of extracts of plant tissues on, [Shipley & others] 1225—ab
experimental, [Protti] 68—ab, [Davis] 1476—ab
experimental, induced by anaphylactic shocks, [Feuillié] 926—ab
experimental, influence of arc light on, [Eckstein] 1404—ab
experimental, influence of hematoporphyrin on, [van Leersum] 254—ab
hydrochloric acid therapy in, [Jones] ★439
in breast fed infants, [DeBuys] 917—ab
incidence of, decline in, [Howland] 158—ab
incidence of, in Peking, [Tso] 1479—ab
intestinal absorption in, 129—E
pathogenesis of, [Gorter & Streng] 2150—ab
phosphate and diastase in urine in, [Hensch & Kramár] 343—ab
tardy, [Baagoe] 1236—ab
treatment of, [Montanari] 68—ab
varying susceptibility to, 1612—E
RADIATIONS: See also Light; Radium; Roentgen Ray
RADIATIONS, radiodermatitis, [Jeanselme & Giraudeau] 1736—ab
and bactericidal power of blood, 2123—E
specific action of, 731
RADIO appeal for blood for transfusion, 1561
radio talks on hygiene, 1797
RADIOACTIVITY, alleged biologic, of potassium salts, 720—E
bioradioactivity and entropy, [Zwaardemaker] 926—ab
visibility of radiant energy, [Laurens] 496—ab
RADIOLOGY, plan to coordinate therapeutic results of, 1626
RADIUM emanations, elective fixation of, 131—E
emanation in therapeutics, [Strasburger] 343—ab
fraud, J. Bernard King's, 1215—P
Ménière's syndrome following use of, [Thompson] ★388
needle, effect of intramuscular radioactive foci, [Dobrovolskaia-Zavadskaia] 1482—ab
physical condition of persons engaged in measuring preparations of, 327—ME
Therapy: See also under Cancer, Goiter, exophthalmic; Leukemia; Thyroid disease; etc.
therapy, 1796
therapy, anuria consecutive to, [Matusovsky] 1486—ab
RADIUM therapy in otorhinolaryngology, [Samengo] 504—ab
therapy, use of, by gynecologists, [Matthews] 1300—ab
therapy, radium as therapeutic agent, [Sanders & Coley] 1471—ab
tubes, 1462
twenty-fifth anniversary of, 316
RALES, significance of, [Allan] 1151—ab
RAT BITE FEVER, [Giraldi] 587—ab, [O'Leary] 1396—ab
relation of spiral organism found in wild rat to, [Mooser] 1648—ab
RATHBONE BILL: See Serum Act
RAYNAUD'S DISEASE, [Castana] 341—ab
and erythromelalgia, [Nobécourt] 1402—ab
RECKLINGHAUSEN'S DISEASE, endocrine phases of, [Tucker] 1297—ab
bone changes in, [Brooks & Lehman] 2146—ab
RECTUM, bilharzial papillomatosis of, [Dolbey & Fahmy] 1229—ab
cancer, [Fischel] ★10, [Kroll] 342—ab
cancer in pelvic large intestine, [Steindl] 2148—ab
cancer, principles for operation of, [Coffey] 235—ab
cancer, surgery of, [Lecène] 1231—ab
examination, new speculum for, [Montague] ★788, [Beach] ★790
prolapse of, new operation for, [Lynch] ★1929
syphilitic stricture of, treated by excision, [Leighton] 238—ab
traumatic injury of, [Marbury] ★1684
RECURRENT FEVER: See Relapsing Fever
RED CROSS conference, Pan-American, 1060
social work, league of, 1795
REFLEXES, eyelid, [Galant] 1657—ab
eyelid, with brain lesions, [Grueter] 169—ab
oculocardiac, in children with goiter, [Thomas] 1305—ab
oculogastric, [Danielopolu & Carniol] 1481—ab
oculovestical, [Pichler] 1743—ab
patellar tendon, effect of alcohol on, [Tuttle] 1893—ab
patellar tendon, effect of sleep on, [Tuttle] 1889—ab
plantar, [Minkowski] 663—ab
posture, in infants, [Magni] 1823—ab
pubic, response of adductors to, [Guillain & others] 1402—ab
recent progress in our knowledge of, [Monrad-Krohn] 508—ab
ty reflex in infants, [Thalwitzer] 1904—ab
REHABILITATION of family life for war victims, [Rodiet] 1737—ab
REJUVENATION: See also under Vas Deferens; Testes grafting
REJUVENATION, some phases of, [Belfield] ★1237
RELAPSING FEVER, cultivating spirochete of, [Sinton] 1652—ab
surgical complications of, [Hesse] 1404—ab
treatment of paralysis with Spirochaeta duttoni infection, [Sagel] 1575—ab
RELIGION, spiritual healing, 403
REPRODUCTION, diet in relation to, [Anderegg] 1891—ab
dietary requirements for, [Sure] 920—ab
new vitamin E influences, [Sure] 920—ab
RESEARCH; that humble individual, 53—ab
grant for, 475
laboratory of, 1706
St. Andrews Institute for, 901
RESPIRATION: See also Air, alveolar
RESPIRATION, action of acids, alkalis and neutral salts, on metabolism in, [Waldbott] 1086—ab
after exertion, [Schott] 1825—ab
aspects of, referable to lungs, [Peabody] 1808—ab
difficulty in inspiration, 740
heart as part of respiratory system, [Robinson] 1808—ab
maximum respiratory output, [Izquierdo] 1901—ab
movements during, [Weltz] 664—ab
nervous control of, [Binger] 1808—ab
paralysis of spiritual healing, 403
pulmonary circulation during, [Kretz] 1486—ab
rate of, factors controlling, [Binger & others] 2077—ab
regulation of, by carbon dioxid, [Lumsden] 660—ab
relation of carbon dioxid and oxygen, [Van Slyke] 1808—ab
tubular, [Martini & Müller] 343—ab
RESPIRATORY TRACT, acute infections of throat and, [Smiley] ★540
and sex function, [Hofbauer] 1156—ab
development of, [Noback] 331—ab
disease, influence of leukopathia and anaphylaxis in production of, [Feuillié] 164—ab
diseases, chlorin in, [Vedde & Sawyer] ★764; 971—E
RESUSCITATION: See also Heart, intracardiac injection
RESUSCITATION from electric shock, 213—E
in apparent death, [Bruns] 505—ab
RETHI, LEOPOLD, death of, 1281
RETICULO-ENDOTHELIAL SYSTEM, 633—E, [Elek] 830—ab
formation of bile pigments, [Whipple] 910—C
RETINA, detachment of, [Jolitrois] 927—ab
hemorrhage of, in malaria, mixed quinin and arsenical treatment of, [Canitano] 1997—ab
pressure in central artery of, [Biledung] 1233—ab
projection of, on primary centers, [Brouwer & others] 663—ab
RETINITIS, albuminuric, [Chabanier & others] 1005—ab
RHEUMATIC FEVER, acute, [Swift] 1640—ab
electrocardiographic evidence of myocardial involvement in, [Cohn & Swift] 998—ab
heart involvement in, 635—E
in children, results of tonsillectomy in, 231
leukocyte curve as index of infection in, [Miller & others] 1988—ab
neocinchophen in, study of, [Boots & Miller] ★1028
pathogenesis of, [Swift] 1647—ab; 1866—E
treatment of, [Danielopolu] 424—ab
RHEUMATISM: See also Arthritis
RHEUMATISM in children and rheumatic heart disease, [Denzer] ★1243
in children; tonsillectomy in relation to its recurrence, [Ingerman & Wilson] ★759
tonsillar and rheumatic infections, 57
RHINITIS, hyperesthetic, cocain spray in, 1286
vasomotor, [Hansel] ★15, [Fløystrup & Kragh] 932—ab
vasomotor, influence of, on tuberculosis, [Kahn] 1392—ab
RHINOSCLEROMA, 405
chemotherapy of, [Jindra] 1744—ab
complement fixation in, [Tomasek] 2000—ab
RHIZOMELIC SPONDYLOSIS: See under Spine
RHUS poisoning, English ivy poisoning, [Highman] 1393—ab
liquid air for poison oak dermatitis, [Donald] 1801—C
RIBS, cervical, and hypertrophy of spinous processes, [Crouzon] 249—ab
cervical, gangrene of finger from, [Otto] 755—ab
RICE in relation to beriberi, [McCarrison] 1300—ab; 1975—E
RICKETS: See Rachitis
RICKETTSIA in relationship to disease, [Wolbach] 1888—ab
RIGIDITY: See Decerebration; Rigor Mortis
RIGOR MORTIS and insulin, [Baur & others] 1089—ab
RIO DE JANEIRO, climate of, 1286
ROCKEFELLER FOUNDATION, gift by, to Edinburgh, 222
what is the matter with "full time"? [Lusk] 1217—C
ROCKY MOUNTAIN SPOTTED FEVER, cultivating organism of, [Wolbach & Schlesinger] 748—ab
immunity studies of, [Noguchi] 61—ab
ROENTGEN Memorials, 225, 733
ROENTGEN RAY SOCIETY prize, 2059
ROENTGEN RAYS, action of, antagonistic, [Dognon] 1653—ab
action of, biologic, [Mayor] 917—ab
action of, on blood, [Lacassagne & Lavedan] 1004—ab
action on bone marrow, [Falconer & others] 1813—ab
action of, on metabolism, [Barreto] 1476—ab
action of, on 8 months fetus? [Peralta Ramos & Bazán] 1573—ab
action of, in body, [Dessauer] 1741—ab
action of, on growing organisms, [Geller] 1740—ab
action of, on stained mice, [Cori] 1992—ab
action of, stimulating, [Gutzeit & others] 1089—ab
and Arndt-Schulz law, [Frik & Krüger] 1090—ab
and blood catalase, [Magat & Rother] 2150—ab
and metabolism, [Bernhardt] 757—ab
artificial radiosensitization of tissues, [Samssonow] 1005—ab
cachexia from, [Martin & Rogers] 1391—ab
changes in larynx from, [Strandberg] 1236—ab
destroys intestinal epithelium but does not increase bacterial invasion, [Warren & Whipple] 335—ab
hereditary abnormalities among roentgenrayed mice, [Little & Bagg] 917—ab
injuries, extensive edema following intensive roentgen-ray therapy, [Anderson] 659—ab
injuries, children bald after roentgen-ray treatment of ringworm, 1209
injuries, tardy ulceration after radiotherapy, [Rahm] 1739—ab
injury, acute suprarenal insufficiency, [Arrillaga & Izzo] 1307—ab
injury and liver, [Neuda & Redlich] 353—ab
injury, intestinal lesions produced by irradiation, [Warren & Whipple] 335—ab
intoxication, acute, [Lignac & Devois] 1655—ab

ROENTGEN RAYS, intoxication, clinical, parallels injury to intestinal epithelium by, [Warren & Whipple] 335—ab
intoxication, treatment of, [Nevermann] 71—ab
martyr, Carnegie Hero Fund to roentgenologist, 313
martyr to, 1209
martyrs, pensions for, 984
offspring after gynecological irradiation, [Apert & Kermorgant] 341—ab, [Unterberger] 344—ab
path of, in tissues, [Warren & Whipple] 335—ab
protection against, [Solomon] 163—ab
service, efficient, fundamental requirements of, in hospitals, [Case] *2071
standard dose, [Küstner] 1902—ab
technic, [Heuser] 505—ab
ulcers, malignant, [Tillmann] 1903—ab
Werner Siemens Institute for Roentgenographic Research, 1282, 1378
ROENTGENOGRAMS, settled law for physicians—as to roentgenograms, 1638—MI
may be taken into jury room, 1886—MI
of privileged nature—examinations, 2144—MI
ROENTGENOGRAPHY, abdominal landmarks of, [Manning] *779
roentgenographic examination for prisoner, 330—MI
ROENTGENOTHERAPY: See also under Cancer; and names of various diseases
ROENTGENOTHERAPY, [Schwarz] 429—ab
comparative effects of deep roentgen-ray therapy at low and very high voltage, [Case] *208
for dental root "abscess," [Bloodgood] 1882—C
of impaired hearing, [Richardson] 1815—ab
ROGER'S IMPROVED ROG-R-PILS, 989—P
ROSS INSTITUTE FOR TROPICAL DISEASES, 728
ROUMANIA, physical deterioration of adolescents in, 486
ROUND LIGAMENT operations for retroversion of uterus, [Ferguson] 246—ab
ossification in, [Calzavara] 1310—ab
ROUX, E., 70th birthday of, 221
ROYAL COLLEGE OF SURGEONS, representation of members in, 221
RUBBER GLOVE SOLUTION, 1802
RUBBER GLOVES, sterilization of, [Schultz] 2000—ab
RUBEOLA: See Measles
RUBIN, HERMAN, and Citrophan, [Hyman] 911—C, [Goldwater] 990—C
RUSSIA, public health work in, 733
Soviet Commissary of Hygiene, [Semaschko] 829—ab

S

SACHS-GEORGI TEST, modification of, [Hata] 1814—ab
SACROCOCCYX, malignant chordoma of, [Andler & Schmincke] 589—ab
SACRO-ILIAC JOINT, bilateral obliteration of, [Woldenberg] *1627
SACRUM, ventral tumors of, [Hundling] 1470—ab, 1478—ab
SAGROTAN, 1199
ST. LOUIS COLLEGE OF PHYSICIANS AND SURGEONS, 1140
SALICYLATE, antiphlogistic effects of, [Hanzlik & Tainter] 336—ab
SALINE CARTHARTICS, effects of, in conditions of dehydration, [Underhill & Kapsinow] *9
SALIVA, apparatus for determination of salivary urea index, [Hench & Aldrich] *1194
SALIVARY GLANDS, metabolism of, [Anrep & Khan] 1301—ab
SALPINGITIS: See under Fallopian Tube
SALT SOLUTION, buffered, use in serology, [Mason & Sanford] 1225—ab
SALVARSAN: See Arsphenamin
SALVATION ARMY medical work, 803
SANIPRACTOR held liable for malpractice—evidence, 1221—MI
SAN-I-SAL, 1800—P
SANITATION as applied to dwellings, 731
foundation of Institute of Sanitary Technic in Paris, 47
SANTONIN, anthelmintic property of, [Calus & Mhaskar] 161—ab
SARCOID of Boeck and lupus pernio, [Martenstein] 1324—ab
SARCOMA cells, cultivation of, outside of organism, [Fischer] 1488—ab
chicken, metastasis of, [Tadenuma] 345—ab
cultures, mouse, clasmatocytes and tumor cells in, [Lewis & Gey] 157—ab
effusion with, [Speroni] 250—ab
giant cell, of bones, prognosis in, [Coley] 1392—ab
in small intestines, [Petersen] 346—ab
localized periosteal, of tibia, [Attix] 237—ab
Peyton Rous infectious chicken sarcoma, [Ellermann] 1488—ab
radiotherapy of, [Régaud & others] 1005—ab
spleen and immunity reactions to, [Lazarus-Barlow & Parry] 160—ab
spontaneous subsidence of, [Cordes] 1739—ab
SCABIES, Danish treatment of, [Greenwood] *466
SCAR: See Cicatrix
SCARLET FEVER, [Dick & Dick] 1724—ab
agent of, [Catteruccia] 586—ab
"antistreptoreaction" in scarlet fever, [Fancon] 1464—ab
antitoxin, [Dick & Dick] *1246
blood in, toxic substance in, [Trask & Blake] 1988—ab
Dick test and Schultz-Charlton test in, [Zingher] 1640—ab
etiology of, [Dick & Dick] *301, [Caronia] 425—ab
heart after, [Hecht] 1008—ab
immune reaction of, 304—E, [Mair] 582—ab
immunization, relation of Dick test to, [Branch & Edwards] *1260
is allergic protein reaction, [Bristol] 495—ab
is it merely a streptococcic anaphylaxis? [Dabney] *956
otitis from, [Harries & Gilhespy] 1820—ab
preventive center against, [Debré & others] 1262
problems, [Herderschée] 507—ab
relationships of streptococcus hemolyticus to, [Doches] 1641—ab
significance of streptococcus hemolyticus in, and preparation of a specific antiscarlatinal serum, [Dochez & Sherman] *542
skin test for susceptibility to, [Dick & Dick] *265
specific streptococcus agglutinins in concentrated scarlatinal serum, [Herrold & Tunnicliff] 1148—ab
the outlook, 1266—E
toxin of, preventive immunization, [Dick & Dick] *544
treatment of, with scarlatinal antistreptococcic serum, [Blake & others] *712, [Blake] 1724—ab
urine in, toxic substance in, [Trask & Blake] 1988—ab
vaccine prevention in, [Sindoni] 1232—ab
[Platelli] 2089—ab
value of extinction tests in, [Toomey & Nourse] 917—ab
Wassermann and Sachs-Georgi reactions in, [Pontano] 1656—ab
SCARLET RED SULPHONATE, 209
SCHIFF'S REAGENT—Fuchsin-sulphurous acid, 228
SCHISTOSOMIASIS, dose of antimony tartrate in, [Christopherson] 581—ab
bilharzial papillomatosis of rectum, [Dolbey & Fahmy] 1239—ab
in China, [Faust] 583—ab
in Northern Brazil, [Cardoso] 166—ab
longevity of bilharzia, [Christopherson] 1735—ab
of ureter, [Ibrahim] 162—ab
treatment of bilharziasis, [Cawston] 1734—ab
SCHOLARSHIPS: See also Fellowships
SCHOLARSHIPS in medicine, 800
physician leaves Scholarship Fund, 800
traveling, 1561
SCHOOLS, epidemics in, 904
examination of school children, 808
medical inspection of institutions of learning, 1134
medical inspection of, in Knoxville, Tenn., [Cunningham] 1472—ab
mental and moral development of children of school age, [Gadelius] 74—ab
SCHOOLS, MEDICAL, modern medical school library, [Gilchrist] *1287
for colored physicians in South Africa, 314
new medical school at Brno, 1377
SCHUTZ, DR. J., death of, 645
SCHWENINGER, ERNST, death of, 562
SCIATICA, instantaneous cure of, [Jaquerod] 1900—ab
roentgen-ray treatment of, [Sanders] 1010—ab
surgical treatment of, [Vollhardt] 831—ab
symptomatic, orthopedic treatment of, [Lewin] *965
SCIENCE, British, 45
medicine and community of scientific thought, 868—E
SCLERA, blue sclerotics, [Bolten] 254—ab
blue, association of, with brittle bones and deafness, [Stobie] 2087—ab
SCLERODERMA and syphilis, [Lortat-Jacob & Legrain] 1006—ab
changes of bones and joints in, [Leontjewa] 1086—ab
SCLEROSIS, disseminated, colloidal gold reaction in, [Adams] 501—ab
disseminated, pathology of, [Symonds] 1896—ab
experimental transmission of, [Blacklock] —ab
multiple, colloidal reactions of cerebrospinal fluid in, [Guillain & Marquézy] 2088—ab
pathogenesis of, [Adams & others] 825—ab
relation of achylia gastrica to, [Vanderhoof] 417—ab
SCOPOLAMIN addiction, [Schaltenbrand] 1007—ab
administration, fatal outcome of, [Bauman] 1157—ab
SCROFULA, severe tuberculin reactions in, [McNeil] 750—ab
SCROTUM as temperature regulator for testes, [Moore & Quick] 1391—ab
elephantiasis of, operation for, [Waller] 65—ab
SCURVY and infection, [Nassau & Scherzer] 1088—ab
infantile, [Miyake] 501—ab
infantile, histology of, [Dalla Valle] 1006—ab
SEASICKNESS, [Dubois] 1303—ab
treatment of, [Genée] 1089—ab
SEBACEOUS CYSTS, generalized steatoma, [Cady] 1076—ab
treatment of, 228
SECRETIN in blood disease, value of, [Downs & Eddy] 418—ab
SECRETIONS, INTERNAL: See Endocrines
SELLA TURCICA, fracture of, [Vergoz] 2083—ab
SEMILUNAR CARTILAGE, neuroma explains failure to recover after removal of, [Dunn] 1816—ab
SEMINAL VESICLES, diagnosis and treatment of diseases of, [Deitzell & Lowsley] *270
in arthritis, with discussion of symptomatology, treatment, [Shea] *274
SEMINAL VESICULITIS after prostatectomy, [Boyd] 1300—ab
test for, [Ballenger & Elder] 62—ab
SENILITY: See Old Age
SENSATION, afferent sensory wave, [Brunschweiler] 1084—ab
SENTENCE, law violated by chiropractor—sentence to hard labor, 494—MI
SEPTICEMIA: See also under Streptococcus
SEPTICEMIA and exhaustion, [Crile] 1224—ab
pneumobacillus, [Lereboullet & Denoyelle] 1303—ab
Puerperal: See Puerperal Infection
treatment of, by intravenous injections of mercurochrome and gentian violet, [Young & Hill] *669
SERODIAGNOSIS: See also under names of various diseases
SERODIAGNOSIS, lecithin in, [Sachs & Klopstock] 167—ab
lipoids in, [Klopstock] 587—ab
SEROSITIS, multiple, in children and adults, [Ponce de León] 68—ab
SEROTHERAPY: See also under names of various diseases
SEROTHERAPY, adenitis from, [Vallery-Radot] 1481—ab
SEROUS CAVITIES, resorption from, [Magnus] 71—ab
SERRATUS ANTERIOR, paralysis of, treatment of, [Haim] 1827—ab
SERUM, and gastric juice, reciprocal relations between, [Kohler] 169—ab
colloidal stability of, in infants, [Nassau & Hendelsohn] 72—ab
hemolytic immune serums, [Kredba] 1827—ab
horse, hypersensitiveness induced by small amounts of, [Hooker] 1225—ab
immune, protection of bacilli by, [Wulff] 827—ab
Normal Horse Serum, 876
orchiepididymitis following antimeningococcus serum treatment, [Guinon & Lamy] 1401—ab
paralysis after antitetanus serum treatment, [Morichau-Beauchant] 163—ab
paralysis after serum treatment, [Lhermitte] 1402—ab
prevention of anaphylaxis by purifying antiserum, [Besredka] 339—ab
residual and purified antiserums, [Schönfelder] 339—ab
sickness following administration of toxin-antitoxin mixture, [Steele] *1262
sickness, late, from diphtheria antitoxin, [Crooks] *109
to obtain a drop of, [van der Hoff] 1010—ab
SERUM ACT, Rathbone bill, 886—E, 900
hearings on, 726
new amendment for, 1270—E
SEWAGE DISPOSAL in primitive community, 1287
SEX characters, quantity of, [Champy] 827—ab
characters, experimental modification of, [Pézard & others] 1904—ab
determination, heredity and sex of progeny, [Bauer] 2149—ab
education, shall children be instructed on sex matters? 730
function, and respiratory organs, [Hofbauer] 1156—ab
human interests, 1050—E
increase of male births, 1061
instinct, erotic sensations and nerve terminals, [Frey] 1405—ab
instinct, frigidity in women, [Lafora] 251—ab
SGAMBATI'S REACTION, value of, in peritonitis, [Deutsch & Graham] 1224—ab
SHATTOCK, SAMUEL GEORGE, 1876
SHAVING BRUSHES, proposed bill to control sale of, 480
SHELLFISH, anaphylactic shock after eating, [Henrichsen] 170—ab
SHEPPARD TOWNER ACT: See Maternity Act
SHIPS, one bill of health for, to Peru, 1791
SHOCK, 903
hematosis in relation to, 1796

SHOCK, physiologic effects of air concussion, 1446—E
postoperative, preoperative digitalization reduces, [Geist & Goldberger] 576—ab
surgical, [Fraser] 923—ab
therapy in insane, [Pascal] 1304—ab
traumatic, [Oltramare & Oltramare] 1997—ab
treatment, paralysis of parasympathetic as basis for, [Gautrelet] 424—ab
SHOULDER, dislocations of, [Schlaepfer] 1143—ab
dislocation of, backward, [Schinz] 1307—ab
dislocation of, recurring, [Oudard] 1004—ab
dislocation, reduction of, [Mallis] 2090—ab
humeroscapular periarthritis, [Franke] 830—ab
pain in, with pathologic processes in pelvis, [Cederberg] 1310—ab
snapping, [Bristow] 929—ab
SIAM, problem of sterility in, 14—ab
SIGHT: See Vision
SIGMOID, acute perforative diverticulitis of, [Jones] 1642—ab
SILICA, influence of, on tissue healing, [Broman] 576—ab
SILICOSIS, bill to make it compensatory, 1371
SILK factories, eye affections in, 808
SILVER compounds, influence of blood on antiseptic efficacy of, [Pilcher & Sollmann] 921—ab
Silver Nitrate Solution 1 Per Cent-Lederle, 391
SIMMONS, GEORGE H., testimonial dinner to, 1978
SINGULTUS: See Hiccup
SINUS: See Maxillary Sinus; Nose, accessory sinuses
de la SIZERANNE, MAURICE, death of, 645
SKI-RUNNERS, injury of knee joint, [Stracker] 1659—ab
blood pressure after ski-races, [Filip] 2094—ab
SKIN, biology of, [Vollmer] 168—ab
cancers, prophylaxis of, [Du Bois] 503—ab
changes of, of thyroid origin, [Bogroff & Krupnikoff] 1824—ab
congenital defect of, [Adair & Stewart] 575—ab
dermatosis from furs, 307—E
disease, basal metabolism in, [Lévy-Franckel & Juster] 826—ab
disease, due to cosmetics, [Cole] ★1909
diseases, common, blood in, [Towle & Swartz] 1899—ab
diseases, heredity in, [Siemens] 1088—ab
diseases, newer methods of treating, [Brocq] 826—ab, [Joseph] 1155—ab
diseases, roentgen-ray therapy of, [Fox] 1076—ab
grafts, blood grouping tests before, [Kubányi] 2090—ab
grafts, protein sensitization in isoskingrafting, [Holman] 658—ab
lesions, trophic, [Dumpert] 1903—ab
physiology of, [Lane] 1148—ab
syphilitic, and liver process, [Kramer] 2150—ab
tuberculosis of, [Yanagihara] 501—ab
SKULL: See Cranium
SLEEP, control of sleeplessness, [Chapman] 1075—ab
insomnia, [Juarros] 231—ab
physiology of, [MacWilliam] 500—ab
SMALLPOX and alastrim, blood in, [Sabrazès & Massias] 239—ab
and chickenpox, blood in, [Hoffman] 158—ab
and chickenpox, diagnosis of, [Painton] 245—ab
during and since the war, [Breger] 830—ab
in various states, 1207
increase, 1794
menace of, 1455
not advising as to care and smallpox, 416—M1
vaccination, 1877
vaccination, Board of Health versus Board of Education as to requiring of, 1069—M1
vaccination, compulsory, in Czechoslovakia, 224
vaccination, history of, [Gins] 1741—ab
vaccination in Tunis, [Dinguizli] 163—ab
vaccination, "killed by vaccination," 552—E
vaccination, neglect of, 221
vaccination, value of, [Rigden] 245—ab
vaccine lymph, standard for, [Cunningham & Cruickshank] 660—ab
vaccine virus, [Levaditi] 1734—ab
SMELL, importance of sense of, in aviators, 316
SMETANA, the musician, disease of, [Hevroch] 2094—ab
SMOKING: See Tobacco
SNAKES, avidity of antitoxins, [Kraus] 1486—ab
damages for illness from chewing snake in tobacco, 1806—M1
venom, concentration of anticobra serum, [Caius & Iyengar] 162—ab
SOCIAL HYGIENE dispensaries, [Kroeff] 426—ab
SOCIAL WORK, national aid in, 223
SODIUM and potassium salts administered intravenously, [Loeser & Konwiser] 1298—ab
bicarbonate intravenously not injurious to kidneys, [Kelliberg] 746—ab
SODIUM bicarbonate, reaction of, 1715
chlorid, parenteral salt fever, [Hoffman & Meyer] 830—ab
chlorid and refraction of tissue fluid, [Gänslen] 1156—ab
citrate, iodid, etc.: See Citrates; Iodids; etc.
poisoning, alkalosis and tetany, [Greenwald] 1224—ab
SOIL, garden, vitamin in, [McCarrison] 161—ab
SOLDIERS: See also Veterans
SOLDIERS, recruiting and mental affections, 485
SPAIN, child welfare in, 732
SPASM, nodding, [Zappert] 1485—ab
nodding, in infant, [Baltasar Hernández Briz] 1232—ab
psychotherapy of spastic conditions, [Moos] 1487—ab
torsion, after epidemic encephalitis, [Bing & Schwartz] 1084—ab
SPASMOPHILIA: See also Tetany
SPASMOPHILIA and tetany, 813
Chvostek's sign in older children, [Pogorschelsky] 829—ab
etiology of, [Johannsen] 1158—ab
heart in, [Schiff] 254—ab
in infants, [Woringer & Zehnter] 340—ab
in gastric ulcer, [Peritz & Fleischer] 1307—ab
low blood calcium in, [Woringer] 240—ab
SPECIES, differentiation of, function-delaying element in embryonal development, [Bok] 668—ab
SPECTRO-CHROME THERAPY, 321—P
SPECULUM, new anal, [Beach] ★790
rectal, new type of, for use in examining and operating, [Montague] ★788
SPEECH and cerebellum, [Seemann] 429—ab
defects, classification and treatment of, [Gifford] ★1673
diseases of, and their treatment, 2063
nature of, 1455
SPINA BIFIDA with hydrocephalus, [Grigsby] 419—ab
and enuresis, [Arnesen] 1828—ab
SPINAL CANAL, roentgenograms of, [Sicard & others] 164—ab
localization of block by means of iodized oil, [Russell] ★1775
perimyelography with iodized oil, [Froment & Dechaume] 1153—ab, [Prusik & Vollcer] 1744—ab
tumors, localization of, [Vincent] 1005—ab
SPINAL CORD, cervical, [Christiansen] 1083—ab
compression of, [Maas] 1088—ab
degeneration of, and pernicious anemia, [Hurst] 823—ab
frequency of discharge from, [Cooper & Adrian] 661—ab
tuberculous softening of, [Roussy & Cornil] 1006—ab
tumor, atypical, [Sharpe] 1727—ab
tumor, surgery plus irradiation of, [Flatau & Sawicki] 1230—ab
tumors, localization of spinal block by means of iodized oil, [Russell] ★1775
tumors, operative treatment of, [Adson] 1000—ab
SPINAL PUNCTURE: See Rachicentesis
SPINE: See also Kyphosis
and arthritis of pyramidal lesions, [Barré] 1304—ab
bone graft for, [Grantham] 1571—ab
congenital defect of thoracic vertebra, [Herzfeld] 1002—ab
curvature of, correction of structural lateral curvature, [Lovett & Brewster] ★1115
curvature, results of fusion operation for, [Hibbs] 920—ab
curvature, scoliosis and gymnastics, [Joland] 164—ab
fracture of articulation of atlas with axis, [Wünsch] 343—ab
fractures of spinal column, [Cleary] 1891—ab
fusion operation on, [Lewin] 920—ab
infectious intervertebral chondritis, [Báron] 2149—ab
injured, immobilization for, [Lundberg] 590—ab
internal splinting of spine, [Magnuson] 658—ab
intervertebral compression of spinal nerves, 34—E
normal variations of vertebrae, [George & Leonard] 1649—ab
osteomyelitis of vertebrae, [Clairmont] 663—ab, [Mathieu] 1084—ab, [Rainmann] 2149—ab
rhizomelic spondylosis from tuberculous rheumatism, [Gonzáles Olaechea] 68—ab
sacralization of lumbar vertebra, [Schüller] 1739—ab
surgery of, [Taylor] 1381—C
syphilitic vertebral process simulating Pott's disease, [González Hurtado] 1483—ab
tuberculosis, diagnosis of latent Pott's disease in adults, [Clavelin] 503—ab
tuberculous kyphosis, treatment of, [Waldenström] 1310—ab
tumor, surgery plus irradiation of, [Flatau & Sawicki] 1230—ab
SPINOUS PROCESSES, fracture of anterior superior spine of ilium, [Carp] 1645—ab
SPIRITUAL HEALING, 403, 643
SPIROCHAETA PALLIDA, arsenic resistant strain of, [Klauder] 1475—ab
demonstration of, in spinal fluid, 1631
in female urethra, [Trost] 1007—ab
penetrate normal mucous membrane, [Brown & Pearce] 1992—ab
SPIROCHETES in uterine cervix, [Couvert] 1154—ab
staining of, [Gilbert & Bartels] 921—ab
SPIROCHETOSIS, bronchial, [Risquez] 69—ab, [Magilone & Palazzo] 1306—ab, [Cassaet & others] 1822—ab
cecal, [Delamare & others] 1736—ab
in rats, [Schüffner & Kuenen] 254—ab, 808
SPLANCHNOPTOSIS: See also Stomach, ptosis
SPLANCHNOPTOSIS, defective circulation with, [Martini] 504—ab
gastropexy; its results and indications, [Rovsing] 1284—C
SPLEEN, abscess of, 1458
and bone marrow, hematopoietic effects of, 797—E
and epinephrin lymphocytosis, [Robitschek & Selinger] 252—ab
and gonads, relations between, [Giunta] 1085—ab
and immunity reactions to sarcoma, [Lazarus-Barlow & Parry] 160—ab
and small lymphocytes, [Lee] 1396—ab
contraction of, under nerve stimulation, [Tournade & Chabrol] 1821—ab
cysts of, nonparasitic, [Gosselin] ★849
echinococcosis, hydatid cyst of, [Mills] 1478—ab
effects of roentgen ray on, [Harbinson] 1727—ab
hematopoietic effect of, and red bone marrow, [Leake] 656—ab
infection of, etiology of chronic infection of spleen, [Gibson] 825—ab
internal secretion of, and pancreas, 1625
irradiation of, in menorrhagia, [Sahler] 1743—ab
palpation of, [Middleton] 746—ab
puncture of, diagnostic, [von Nagy] 1007—ab
rupture of, [McCracken] 821—ab
rupture of, traumatic, [Wallace] 657—ab
sagging, [Gallino & Gonzalez] 1484—ab
spontaneous rupture of spleen following a carbuncle, [Diehl] ★951
tuberculous cyst of, splenectomy; recovery, [Peck] 235—ab
SPLENECTOMY, [Malone] 1472—ab
artificial ischemia as aid in, [Huber] 1086—ab
as treatment for purpura hemorrhagica, [Cohn] 236—ab
bloodless, [Hess] 2091—ab
for essential thrombopenia, [Engel] 2090—ab
in splenic anemia, [Boland] 236—ab
in treatment of hemorrhagic diathesis, [Wild] 1741—ab, (Correction) 2000—ab
indications for, [Kaznelson] 170—ab
liver after, [Schmidt] 1405—ab
spleen and biliary secretion after, [Inlow] 745—ab
SPLENOMEGALY and leukopenia, arthritis associated with, [Felty] 747—ab
SPLINT, barrel stave, 228, 491
improved sercoplane splint, [Fitchet & Thorndike] ★1120
improved Hodgen's wire suspension splint, [Nauth] ★1692
SPONDYLOSIS: See under Spine
SPORES, heat resistance of, [Esty & Williams] 1893—ab
SPRUE and pernicious anemia, [Bramwell] 1228—ab
calcium deficiency in, a parathyroid dysfunction, [Scott] 337—ab
tropical, [Rosenfeld] 1732—ab
SPUTUM, flagellate protozoon in, [Knowles & Das Gupta] 1651—ab
homogenization of, [Ronchèse] 826—ab, [Torrazza] 1900—ab
leucin and tyrosin in, [Teligmann] 427—ab
tuberculous, disinfection of, 487
STAINING, acetone and iodin-acetone decolorizer for spores and tubercle bacilli, [Burke & Dunning] 1078—ab
solution for laboratory tables, 1802
STAMMERING, [Röschels] 756—ab
Dr. Fröschels on, 645
etiology of, [Sachs] 931—ab
STAPHYLOCOCCUS COMBINED VACCINE, 1047
STARCH, raw, experiments with, 1064—ab
STARVATION, inanition and organs of children, [Nicolaeff] 249—ab
changes in brain during, [Hassin] 1815—ab
prolonged, increase of uric acid in blood during, [Lennox] ★602
STATE BOARD REPORTS, Alabama, 492, 1565
Colorado, 2073
Delaware, 912
District of Columbia, 412, 2074
Florida, 325
Georgia, 650
Hawaii, 54, 912, 129

STATE BOARD REPORTS, Idaho, 325
Illinois, 741, 1985
Iowa, 2074
Kansas, 1635
Kentucky, 741
Massachusetts, 54, 994
Michigan, 570, 650, 741
Minnesota, 492, 1716
Missouri, 570, 1803
Montana, 1290
National Board, 814
New Mexico, 1220
New York, 2140
North Dakota, 1716
Ohio, 326, 912, 1383
Oklahoma, 1462
Oregon, 1383
Pennsylvania, 229, 1634
Porto Rico, 326
question, 1718
Rhode Island, 54
South Carolina, 412
South Dakota, 1635
Vermont, 2074
Washington, 1565, 1803
West Virginia, 1462
Wisconsin, 1220, 1894
statistics of, 1362—E
statistics for 1923, annual presentation by Council on Medical Education and Hospitals of the American Medical Association of results of state board examinations, 1343
STATUS LYMPHATICUS, lymphatic temperament, [Kjerrulf] 430—ab
in children, [Adkins & Freeman] 1811—ab
STEINACH OPERATION: See under Vas Deferens
STERILITY, body heat causes, [Moore & Oslund] 998—ab
in female, [Smythe] 1390—ab
in men, cause of, [Read] 922—ab
incidence of venereal disease in cases of, [Spalding] 60—ab
operative treatment of, [Graff & Petzoid] 756—ab
problem of, in Siam, 14—ab
Transuterine insuflation of gas in: See Fallopian Tube
treatment of, [Dietrich] 931—ab
STERILIZATION, SEXUAL, hormonal sterilization of females, [Haberlandt] 72—ab
interruption of, pregnancy and sterilization through abdominal incision, [Rosenstein] 1742—ab
temporary, with roentgen rays, [Naujoks] 756—ab
use of antispasmodic drugs in combination with transuterine insuflation of gas in, [Meaker] *2098
STETHOSCOPE, multiple electrical, for teaching, [Gamble & Replogle] *387
combination stethoscope, [Moss] *2118
STINTZING, PROFESSOR, birthday of, 905
STOMACH acidity, "free acidity (organic and inorganic)", [Hubbard & Meeker] *1342
acidity, free, [Sahli] 586—ab
acidity, gastric germicidal barrier, 206—ab
acidity of gastric juice in infants, [Marriott & Davidson] 331—ab, [Klementsson] 1158—ab
action of pilocarpin on, [Kalk] 1307—ab
anomalies, microgastria, [Hoyt] 1570—ab
atonic insufficiency of, causes vomiting in infants, [Lindberg] 1223—ab
cancer, 645, [Schönbauer & Orator] 756—ab
cancer and gastric achylia, [Zweig] 1825—ab
cancer of, and pregnancy, [Schmid] 1085—ab
cancer, early diagnosis of, [Cortes Llado] 1306—ab, [Christian] 1726—ab, *2011
cancer, gastric ulcerations, [Pauchet & Hirschberg] 584—ab
cancer, gastro-intestinal linitis, [Bensaude & others] 248—ab
cancer in gastric ulcer, [Finsterer] 168—ab
cancer in young people, [Sullivan] 235—ab
cancer, preceding symptoms of, [Goldie] 749—ab
cancer, prognosis of, [Cheever] 1224—ab
cancer, pylorectomy after gastroduodenostomy for, [Cohn] 1145—ab
cancer, Tansini sign of metastasis of, [Della Mano] 1084—ab
cancer, total gastrectomy for, [Schüppel] 2149—ab
cancer, Wolff-Junghans reaction in, [Riabow & Smotrow] 1824—ab
chromodiagnosis of, [Hirabayashi] 1824—ab
contents, duodenal tube for examination of, [Bársony & Friedrich] 1745—ab
contents, test meal, [Boas] 252—ab
crises, vagotomy in, [Thomsen] 932—ab
denervation of, [Latarjet & Wertheimer] 249—ab
desmoid reaction, fallacy of, [Sahli] 51—C, [Buckstein] 146—C
dilated, asystolia of stomach, [Martini] 1154—ab
diseases of, [Citron] 829—ab
disturbances of, from unsuspected disease of aorta, [Monge] 341—ab
effect on, of different breakfasts, 225
STOMACH, enlarged, operation to correct, [Dreifuss] 2090—ab
examination, introduction of gastrocystoscope, [Sternberg] 758—ab
foreign bodies in, [Griffith] *31
function, stain test of, [Koopman] 2150—ab
function tests, [Grote] 1902—ab
gastric hypertonia and hyperkinesia of neuropathic origin, [Timbal] 1005—ab
gastroscopy and exploratory laparotomy, [Hammesfahr] 1157—ab
hematemesis "without" apparent lesions, [Monod] 1819—ab
hour-glass, double gastro-enterostomy for, [Gibson] 241—ab
inflammation, chronic, [Konjetzny] 1657—ab
innervation, circulatory responses to gastric disturbances, [Dmitrenko] 1889—ab
leukopedesis, action of atropin on secretion of hydrochloric acid and, [Loeper & Marchal] 2088—ab
motor insufficiency of, treatment of, [Klein] 2090—ab
mucosa, immune serum against, [Tadenuma] 1999—ab
mucosa, spontaneous regeneration of, after resection, [Michon & Magrou] 1231—ab
myoma of, [Weber] 345—ab
nerves, afferent innervation of stomach, [Pi Suñer & Puche] 1654—ab
nerves, lesions of, [Loeper & Turpin] 503—ab
neuroses, surgery and nervous stomach affections, [Pribram] 1825—ab
ptosis, [Edholm] 932—ab
ptosis, dolichogastry, [Martini] 426—ab
ptosis, gastropexy, [Kutscha-Lissberg] 2092—ab
ptosis, intermittent, [Martini] 754—ab
Pylorus: See Pylorus
sagging, surgical treatment of, [Marchesini] 753—ab
sarcoma of, [Lindboe] 1310—ab
secretion and "alkaline tide" in urine, [Hubbard & others] 1889—ab
secretion, effect of hunger on, [Kunde] 1889—ab
secretion, gastric juice and pyloric stomach, [Koennecke & Jungermann] 72—ab
secretion of, in children, [Klementsson] 1158—ab
secretion of, in psychoses, 548—E
secretion of, in relation to intestinal factors, 1200—E
secretion of, reciprocal relations with blood serum, [Kohler] 169—ab
secretion, postoperative, [Stein & Fried] 253—ab
secretion, stomach function test, [Glässner & Wittgenstein] 253—ab
secretion, variations in, [Bell & MacAdam] 1727—ab
stenosis of, chloroform in, [Loeper & others] 1153—ab
surgery, treatment after, [Singer] 1903—ab
surgery, value of feeding during operations, [Brown] 1995—ab
syphilis of, [Guerrero] 753—ab
tuberculosis of, [Willerding] 1086—ab
tumor, ball valve, symptoms manifested by, [Matas] 499—ab
tumors, benign, roentgenologic signs of, [Moore] 820—ab
Ulcer: See Peptic Ulcer
STOMATITIS, aphthous, etiology of, [Gans] 1308—ab
following injection of mercurochrome-220 soluble in tuberculous sinus, [Guy] *2119
rebellious aphthae on buccal mucosa, [Cervera] 929—ab
STOMATOLOGY, [Miner] 1077—ab
STRABISMUS, nonsurgical management of, [Iler] 1383—ab
treatment of, [de Andrade] 2090—ab
STREPTOCOCCI agglutinins, specific, in concentrated scarlatinal serum, [Herrold & Tunnicliff] 1148—ab
changes in, from encephalitis, [Rosenow] 244—ab
culture medium for, [Ayers & Johnson] 1395—ab
effect of animal passage on, [Howell] 1078—ab
hemolytic, differentiation of, [Bloomfield & Felty] 334—ab
hemolytic, in acute tonsillitis, [Felty & Bloomfield] 157—ab
hemolytic, in pregnancy, [Kanter & Pilot] 658
hemolytic, of human origin in milk, [Beckwith & Eddie] 1225—ab
hemolytic, relationship of, to scarlet fever, [Dochez] 1641—ab
hemolytic, significance of, in scarlet fever, [Dochez & Sherman] *542
hemolytic, types of, [Ando & Chen] 253—ab
in blood, [Freund & Berger] 2091—ab
nonhemolytic, sensitization of joints with, [Swift & Boots] 61—ab
of souring milk, [Ayers & others] 498—ab
pigment-producing, [Durand & Giraud] 584—ab
STREPTOCOCCI produce hydrogen sulphid, [Ayers & Johnson] 1395—ab
relation of growth activity to pathogenicity of, [Bloomfield] 1888—ab
resistance of, [Louros] 73—ab
septicemia, chronic streptococcus infections, [Jungmann] 755—ab
specificity of, in etiology of diseases of nervous system, [Rosenow] *449, 1988—ab
Streptococcus Vaccine, 1047
virulence of, [Philipp] 72—ab, [Ruge] 1738—ab
STRIDOR, syphilitic false croup, [Garrahan] 426—ab
STRONTIUM, analgesic action of, [Alwens] 1901—ab
STROPHANTHIN, digitalis group and blood vessels, [Ganter] 1903—ab
STROPHANTHUS KOMBE, [Morris] 63—ab
STUDENTS, honor loans to, 1279
medical, visit of, from Scotland, 1562
SUBSIDIES, federal, President's disapproval of, 396—E
SUGAR elimination in new-born, [Langer] 666—ab
excretion, influence of diuretics on, [Conway] 661—ab
excretion, relation of, to renal integrity, [Underhill & Wilens] 243—ab
in Blood: See Blood, sugar in
in Urine: See Glycosuria; Urine, sugar in
ingestion of, and hydremia, [Meyer-Bisch] 665—ab
insulin and decomposition of, [Neuberg & others] 251—ab
SUGGESTION, psychophysical reaction, [Piesch] 1087—ab
SUICIDE in Parkinson's disease, 47
with formaldehyd solution, [Vercalli] 1483—ab
SULPHARSPHENAMIN, pain after use of, 759
SUNLIGHT: See Heliotherapy; Light
SUPRARENALECTOMY, intravenous anesthesia for experimental research, [Soler & others] 504—ab
susceptibility of suprarenalectomized rats to morphin, [Scott] 61—ab
SUPRARENALS, calcification of medulla of, [Newsam] 1397—ab
carcinoma of, associated with unusual endocrine manifestations, [Keyser & Walters] *87
Extract: See Epinephrin
hemorrhage of, in new-born, [Corcoran & Strauss] *626
hypertrophy, cause of, in inanition, [McCarrison] 660—ab
hypertrophy, compensatory, [Boycott & Kellaway] 1734—ab
influence of, on resistance, [Scott] 1396—ab
insufficiency, acute, [Schierbeck] 74—ab, [Berisso & Godoy] 167—ab
insufficiency, acute, from roentgen-ray exposures, [Arrillaga & Izzo] 1307—ab
insufficiency following venous obstruction, [Elman & Rothman] 1147—ab
relationship of, to sugar in blood, [Griffith] 155—ab
suprarenal virilism, [Berner] 74—ab, [Collet] 1223—ab
suprarenal virilism and pseudohermaphrodism, [Scabell] 2092—ab
suprarenal virilism in hen, [Berner] 1006—ab
tumors of, association of hypertension with, [Oppenheimer & Fishberg] 2077—ab
"SURGEON and physician" and "naturopath" defined—practice, 1293—MI
effect of his professional life on his health, [Laqua] 1157—ab
SURGERY: See also Incisions; Instruments; and under names of organs and regions
SURGERY, blood after, [Schönbauer & Eichelter] 1743—ab
blood pressure in, [Coburn] *1748
blood sedimentation test in surgical diagnosis, [Friedlaender] 1145—ab
in prehomeric Greece, 1212
inhalation of oxygen in, [Panis] 2088—ab
military, confessions of a German war surgeon, 1269—E
of mastitis and felons, [Ciminata] 1405—ab
plastic, clinic for, 222
plastic, for chest defects, [Romiti] 1084—ab
postoperative massive pulmonary collapse, [Leopold] 1474—ab
postoperative pulmonary complications, [Lee] 1645—ab
technic, simplicity of, [de Tarnowsky] *1505
where it has gone astray, [Liek] 1155—ab
SURVIVORSHIP, 330—MI
SUTURES, painless method for removal of, [Fox] *33
removal of deep, [Smith] *206
unabsorbable, cause jejunal ulcer, [Renton] 500—ab
SWEAT GLANDS, functions of, 968—E
SWEDEN, principles of organization of Public Medical Relief Service in, [Nordenson] 590—ab
SWEET POTATOES, vitamin C in, [Peck] 1479—ab
SWIMMING POOLS, licensing of, to prevent infection, [Moore] 1732—ab

SWINE ERYSIPELAS in human finger joints, [Rahm] 930—ab
SYDENHAM, methods of, (1624-1689), 1127—E
ceremonies in honor of tercentenary of, 2062
SYMPATHECTOMY: See also under Angina Pectoris
SYMPATHECTOMY, femoral, bilateral, [Campbell] 658—ab
periarterial, [Lahoz] 929—ab, [Hohlbaum] 1741—ab, [Brandenburg] 1826—ab, [Wiedhopf] 1902—ab
periarterial, action of, [Wiedhopf] 427—ab
periarterial, in migraine, [Hellwig] 1086—ab
periarterial, in tuberculosis of extremities, [Läwen] 1156—ab
periarterial, partial, [Kreuter] 506—ab
periarterial, physiology of, [Schilf] 1155—ab
SYMPHYSIOTOMY, subcutaneous, [Ostrcil] 346—ab
SYMPTOMS, artificial, [Leven] 67—ab
SYNOSTOSIS, radio-ulnar, [Davenport & others] 2080—ab
SYPHILID, collar of Venus; melanoleukoderma colli of syphilis, [Goodman] ★701
SYPHILIS, abortive treatment of, [May] 929—ab, [Mutschler] 1824—ab
and childbirth, [Urech] 827—ab
and diabetes, [Villaret & Blum] 1004—ab
and obstetrics, [Roberts] 64—ab
and pregnancy, [Klaften & Kalman] 253—ab, [Kiee] 1486—ab
and pregnancy; mercuric cyanid in pregnancy, [Sauphar] 1899—ab
and scleroderma, [Lortat-Jacob & Legrain] 1006—ab
and tuberculosis, [Samson] 666—ab
as complication of tuberculosis, [Bowman] 338—ab
as factor in etiology of mental deficiency, [Weiss & Izgur] ★12
blood in, specific syphilitic substance in syphilitic serum, [Taoka] 1814—ab
blood in, syphilitic pseudoleukemia, [Nanta] 1737—ab
congenital, [Yamposky] 1298—ab
congenital, and rickets, [Cozzolino] 2089—ab
congenital, bismuth in, [Beretervide & Thénon] 1307—ab, [Frank] 1657—ab
congenital, early diagnosis of, [Vulovic]428—ab
congenital, early, sulpharsphenamin in, [Boone & Weech] 575—ab
congenital, hereditary syphilitic eye, [Wätzold] 587—ab
congenital, importance of newer serologic tests for, [Ssirmal] 1404—ab
congenital, in Welander homes, [Rosenthal] 1088—ab
congenital, molars in, [Pflüger] 2093—ab
congenital, prophylaxis of [Almkvist] 1660—ab
congenital; public health problem, [Lawrence] ★1252
congenital, treatment of [Fordyce & Rosen] 1394—ab, [Italiener] 1740—ab
decrease in, 1059
diagnosis of, comparative research on, [Boas & others] 832—ab
dispensary, antisyphilitic, at Maternity Hospital in Antwerp, 2132
experimental, [Klarenbeek] 67—ab
experimental, determining cure by antisyphilitic remedies, [Chesney & Kemp] 1648—ab
experimental, encephalitis in syphilitic rabbits, [Plaut & Mulzer] 756—ab
experental, factors influencing course of, [Chesney] 62—ab
experimental, serodiagnosis of, [Georgi & Steinfeld] 428—ab
fever late in possibly unrecognized syphilis, [Bloch] 2088—ab
free treatment of, [Fraga] 929—ab
gynecologic, [Farani] 426—ab
in children, acquired, [Jaureguy] 1900—ab
in children given thorough treatment, [Meyer] 1657—ab
in infants, [Arata] 1483—ab
in 1924, [Millian & Brodier] 1153—ab
influnce of soft chancre on, [Haxthausen] 239—ab
intracutaneous horse serum and gelatin test in, [Gutmann & Kropatsch] 1008—ab
irregular practitioners and transmission of, [Pinkus] 169—ab
is curable, [Kilduffe] 1076—ab
isolated pupil anomalies as guide for treatment, [Thaysen] 758—ab
of Nervous System: See Neurosyphilis
phenoltetrachlorphthalein liver test in cases of syphilis under treatment, [Greenbaum & Brown] ★88
prognosis of, [Arpási] 589—ab
prophylactic use of arsphenamin, [Rostenberg] ★207
pruritus in, [Greco] 69—ab
Query antisyphilitic serum, 224
reinfection in, [Reasoner] 1813—ab
SYPHILIS, secondary, untreated, hemianopia in, [Sichel & Fraser] 241—ab
Serodiagnosis: See also Kahn Test; Kolmer Test; Wassermann Reaction; etc.
serodiagnosis, [Adler & Sinek] 168—ab
serodiagnosis, biologic tests in syphilis, [Businco & Foltz] 2089—ab
serodiagnosis, flocculation test for syphilis, [McGlumphy] 2083—ab
serodiagnosis, comparative serologic tests, [Boas & others] 1236—ab
serodiagnosis, dissolution of precipitates in, [Taoka] 253—ab
serodiagnosis of, and colloids, [Stern] 1575—ab
serodiagnosis, precipitation tests for, 1883
serodiagnosis, ring test in, [Stern] 1233—ab
serologic control of, [Oltramare] 1004—ab
superinfection, chancre in juvenile with general paralysis, during antisyphilitic treatment, [Shinkle] ★1780
syphilitic septicemia in nursling, [Sillitti] 249—ab
treated, changes in weight in, [Sutton] 60—ab
treatment of, [Dind] 165—ab
treatment, bismuth in, [Hudelo & Rabut] 1655—ab
treatment of, coexistent with condition simulating diabetes, [Paullin & Bowcock] ★702
treatment, early, [Irvine] 1146—ab
treatment, effect of, on kidney, [McFarland] 1727—ab
treatment, flumerin in, [Snodgrass] 824—ab
treatment, tryparsamide in, [Moore & others] ★528
treatment, passage of bismuth into cerebrospinal fluid, [Jeanselme & others] 1304—ab
treatment, sulpharsphenamin in, [Belding] 1475—ab
treatment, supplementing specific spirochetlcide therapy, [Ahlswede] 822—ab
treatment, syphilitic meningitis after arsenicals, [Roch] 1482—ab
treatment with inunction with mercury, [Cole & others] ★199
unsuspected, [Connor] 1894—ab
visceral, treatment of, [Keidel & Kemp] ★299
SYRINGOMYELIA, [Achard] 1006—ab

SOCIETIES

Acad.—Academy
A.—Association
Am.—American
Coll.—College
Conf.—Conference
Cong.—Congress
Conv.—Convention
Dist.—District
Hosp.—Hospital
Internat.—International
M.—Medical or Medicine
Nat.—National
Phar.—Pharmaceutical
Phys.—Physicians
Ry.—Railway
S.—Society
Surg.—Surgical or Surgeon, Surgery

Adams County (Ill.) M. S., 553, 723, 978, 1368, 1787
Alabama, M. A. of the State of, 477, 978, 1367
Alabama State Hosp. A., 1556
Alameda County (Calif.) M. S., 722
Allegheny County (Pa.) M. S., 1274, 1701
Allied Professions of Brooklyn, 897
All-Philadelphia Conf. on Social Work, 1274
Alpha Kappa Kappa, 726
Am. Acad. of Ophth. and Otolaryngology, 1452, 1556
Am. Acad. of Physiotherapy, 1702
Am. A. for the Advancement of Science, 136, 401
Am. A. of Anatomists, 1452
Am. A. for Cancer Research, 1559
Am. A. of Genito-Urinary Surgs., 1978
Am. A. of Hosp. Social Workers, 133, 1559
Am. A. of Industrial Phys. and Surgs., 1699
Am. A. of Museums, 641
Am. A. for the Study of Allergy (formerly the Am. A. for the Study of Hay-Fever), 1699, 1868
Am. A. for the Study of Goiter, 481, 1699
Am. Bacteriologists, S. of, 401
Am. Chemical S., 1207, 1449
Am. Child Health A., 477, 1055, 1130, 1452, 1702
Am. Cong. on Internal M., 219, 727
Am. Gastro-Enterological A., 1702
Am. Gynecological S., 1873
Am. Heart A., 1791
Am. Hosp. A., 401, 799
Am. Institute of M., 1701
Am. Laryngol. Rhinol. and Otol. S., 900, 1978
Am. Library A., 899
Am. M. A. (Woman's Auxiliary), 1367
Am. Orthopedic A., 1699
Am. Pathological S., 481
Am. Phar. A., 218, 641
Am. Physical Education A., 900
Am. Physiological S., 481
Am. Physiotherapy A., 1702
Am. Proctologic S., 219, 726
Am. Psychological A., 311
Am. Public Health A., 899
Am. Radium S., 896, 1699
Am. Red Cross, 136, 1207, 1276, 1619, 1795
Am. Roentgen-Ray S., 2059
Am. S. of Biological Chemistry, 481
Am. S. for Clinical Investigation, 1988, 2077
Am. S. of Clinical Pathologists, 726
Am. S. for the Control of Cancer, 900
Am. S. of Tropical M., 896
Am. Student Health A., 312
Am. Surg. A., 1368, 1371
Am. Therapeutic S., 641, 1872
Argentine M. A., 43
Arizona State M. A., 1615
Arkansas M. S., 308, 1869
Associated Phys. of Long Island, 478
A. of Am. M. Coll., 42, 312, 803
A. of Am. Orthopsychiatrists, 1978
A. of Am. Phys., 1619, 1721, 1807, 1886
A. of Am. Teachers of Diseases of Children, 2059
A. of Assistant Phys. in State Hosps., 1701
A. for the Development of M. Relations Between France and Allied Countries, 223
A. for the Prevention of Heart Disease, 310
A. for the Study of Internal Secretions, 1873
Austrian Anti-Cancer S., 1708
Austrian Tuberculosis S., 2063
Australasian M. Cong., 402
Baltimore County (Md.) M. S., 309, 638
Belgian Chirurgical S., 558
Belgian Nat. League Against the Venereal Peril, 804
Berlin Microbiological S., 557
Bologna, Medicosurgical S. of, 1703
Boston A. for the Prevention and Relief of Heart Disease, 40
Boston Tuberculosis A., 724
British A. for the Advancement of Science, 402, 804, 1619, 1873
British Council of the Federation of M. Women, 1703
British Imperial Social Hygiene Council, 983
British M. A., 1277, 2060
British M. A. (New Zealand Branch), 1620
British M. A. (Tasmanian Branch), 1792
British Nat. Council for Combating Venereal Disease, 983
British Nat. Union of Scientific Workers, 982
Bronx County (N. Y.) S., 554
Brooklyn S. of Internal M., 1977
Brussels M. Conv., 1877
California M. A., 1128, 1787
California S. for the Blind, 38
Canadian M. A., 726, 1619
Canadian Public Health A., 556
Canadian Roentgen S., 481
Canadian Social Hygiene Council, 218
Canadian Tuberculosis A., 899
Caracas (Venezuela) M. S., 557
Central Illinois M. S., 1698
Central Minnesota M. A., 309
Central Oregon M. S., 1274
Central Portugal, M. A. of, 982
Central Rhineland Surg. A., 137
Central States Pediatric S., 312
Chattanooga (Tenn.) County M. S., 1452
Chicago A. for the Prevention and Relief of Heart Disease, 397, 553
Chicago Council of M. Women, 723, 896
Chicago Infant Welfare S., 309, 1052
Chicago Laryngological and Otological S., 39
Chicago M. S., 133, 397, 477, 723, 896, 1272, 1368
Chicago Neurological S., 896
Chicago Ophthalmological S., 397
Chicago Pathological S., 133, 896, 1616
Chicago S. of Anesthetists, 397, 896
Chicago S. of Industrial Phys. and Surgs., 2057
Chicago S. of Internal M., 397
Chicago Tuberculosis S., 1787
Chicago Urological S., 397, 1869
China, Nat. M. A. of, 1276
Cleveland Acad. of M., 1205
Colorado Ophthalmological S., 799
Conf. Board of Phys. of Industry, 1205
Cong. of French-Speaking Pediatricians, 1795
Cong. of German Natural Science and M., 1620
Cong. on M. Education, Licensure, Public Health and Hosps., 219, 799, 899
Cong. on Occupational M., 1559
Connecticut, M. Women's S. of, 1367, 2056
Contra Costa (Calif.) M. S., 214
Czechoslovak A. for Combating Venereal Diseases, 405
Denver City and County M. S., 553
Des Moines County (Iowa) M. S., 723
District of Columbia, M. S. of the, 477, 799, 1271, 1698, 1787
District of Columbia, S. of Psychanalysts, 1368
Dubuque County (Iowa) M. S., 723
Durham County (Ont.) M. A., 1978

Eastern M. S., 1557
England, Cremation S. of, 1703
Fairfield County (Conn.) M. S., 2056
Far Eastern A. of Tropical M., 557
Federation of State M. Boards, 899
Florida Anti-Mosquito A., 133
Florida M. A., 1869
French Acad. of M., 137
French Chirurgical S., 557
French Cong. of Legal M., 223, 1134, 1703
French Cong. of Ophthalmology, 1210, 1370
French Nat. Cong. of Ophthalmology, 1703
French Nat. Cong. of Surgs., 1703
French Nat. Orthopedic Cong., 1703
French S. of Biology, 1703
French-Speaking Alienists and Neurologists, 982
Georgia, M. A. of, 1615, 1810
German Cong. for Diseases of Digestion and Metabolism, 982
German Cong. for Internal M., 557, 2064
German Orthopedic S., 1620
German Roentgen S., 982
German Woman's Nat. M. A., 1559
Golden Belt (Kansas) M. S., 1272
Great Britain, Visiting A. of Throat and Ear Surgs. of, 982
Hartford County (Conn.) M. S., 1368
Harveian S. of London, 982
Hawaii, M. S. of, 1872
Health Education Conf., 1275
Hennepin County (Minn.) M. S., 1369
Hudson County (N. J.) M. S., 801
Idaho Falls M. S., 1787
Illinois Crippled Children's S., 133, 553
Illinois Hosp. A., 723
Illinois S. for Mental Hygiene, 896
Illinois State Acad. of Science, 1869
Illinois State M. S., 1616, 1787
Illinois Tuberculosis A., 799, 1787
Indiana Acad. of Ophthalmology and Otolaryngology, 397
Indiana S. for Mental Hygiene, 133
Indiana Tuberculosis A., 1556
Indianapolis M. S., 394
Internat. Anti-Tuberculosis Union, 1453
Internat. A. of M. Museums (Am. and Canadian sections), 1559
Internat. A. of Urology, 1556
Internat. Cong. for Comparative Pathology, 727, 1620
Internat. Cong. of Deaf Mutes, 318
Internat. Cong. of Industrial Health, 220
Internat. Cong. of Military M. and Pharmacy, 1620
Internat. Cong. of the Red Cross, 140
Internat. Cong. of Urology, 137
Internat. Federation of University Women, 1700
Internat. Health Conf., 1791
Internat. S. of Applied Psychology, 43
Internat. S. for Crippled Children, 803
Internat. S. of the History of M., 43, 727, 1703
Internat. Union Against Venereal Peril, 1208
Internat. Union of Pure and Applied Chemistry, 1792
Iowa Radiological and Physiotherapy S., 979
Iowa S. of M. Women, 1787
Iowa State M. S., 1699
Iowa Trudeau S., 637
Iowa Tuberculosis A., 637
Irish M. A., 1792
Isthmian Canal Zone, M. A. of, 218, 400
Italian A. of M. Women, 1559
Italian Cong. of M. Roentgenology, 317
John Andrew Clinical S., 1552, 1449
Kansas City (Mo.) Clinical S., 1617
Kansas M. Laboratories A., 39
Kansas M. S., 477, 1699
Kansas Mental Hygiene S., 1559
King County (Wash.) M. S., 400, 556, 1206, 1452
Kings County (N. Y.) M. S., 310, 801, 1053, 1129, 1700, 1789
La Crosse County (Wis.) M. S., 726
Lawrence County (Pa.) M. S., 555
League of German Women Phys., 1459
League of Nations, 136, 482, 641, 727, 985, 1276, 1371, 1453, 1980
Liverpool Psychological S., 220
Lonoke County (Ark.) M. S., 1128
Los Angeles County (Calif.) M. S., 1052
Louisiana State M. S., 1449
Madrid Medico-Chirurgical Acad., 220
Maritime Quarantine, Conf. on, 400, 1275
Maryland, M. and Chirurgical Faculty of, 1450
Maryland Tuberculosis A., 1129
Massachusetts Dietetic A., 979
Massachusetts M. S., 979, 1588
Massachusetts Psychiatric S., 1977
Massachusetts S. of Examining Phys., 1788
Massachusetts Tuberculosis League, 1788
M. and Surg. A. of the Southwest, 42
M. Woman's Internat. A., 1619
Michigan Conf. of County Secretaries, 1368
Michigan Hosp. A., 554
Mid-Columbia (Ore.) M. S., 1274
Middle Tennessee M. A., 1872
Midwest Texas District M. S., 1452
Milwaukee Acad. of M., 311, 1452
Milwaukee County M. S., 42
Milwaukee County Roentgen S., 556
Milwaukee Neuropsychiatric S., 640
Milwaukee Oto-Ophthalmic S., 802
Minneapolis Surg. S., 979
Mississippi State M. A., 1870
Missouri State M. A., 1617
Nat. Acad. of Sciences, 1207, 1556
Nat. Child Labor Committee, 1787
Nat. Committee for the Disabled, 1671
Nat. Committee for Mental Hygiene, 219, 1559, 1702, 1790
Nat. Committee for the Prevention of Blindness, 43, 1702
Nat. Committee for the Prevention and Relief of Heart Disease, 1791
Nat. Conf. of Social Work, 1371
Nat. Cong. on Health, 898
Nat. Drug Trade Conf., 219
Nat. Health Council, 981, 1371
Nat. Malaria Committee, 1131
Nat. M. Cong. (Pa.), 1054
Nat. M. Cong. in Venezuela, 1979
Nat. Memorial A., 1559
Nat. Organization for Public Health Nursing, 900, 1276
Nat. Research Council, 1791
Nat. Safety Council, 136, 803, 1451
Nat. Tuberculosis A., 219, 899, 1699, 1791, 2059
Nebraska Acad. of Ophthalmology and Oto-Laryngology, 2057
Nebraska A. of M. Women, 1870
Nebraska State M. A., 1870
New England Health Institute, 1788
New England Pediatric S., 218, 1700
New England Surg. S., 218
New Jersey Health Officers' A., 724
New Jersey, M. S. of, 2057
New Mexico Health Officers' A., 1700
New Mexico M. S., 1870
New York Acad. of M., 479, 980, 1129, 1274, 1558, 1618, 1701, 1874
New York A. for Improving the Condition of the Poor, 1700
New York A. of Public Health Laboratories, 1617
New York County M. S., 1789
New York Electrotherapeutic S., 134
New York Gastro-Enterological S., 216
New York, M. S. of the State of, 478, 554, 1451, 1567, 1639
New York Pathological S., 478
New York S. of Anesthetists, 1205
New York S. of M. Jurisprudence, 1700
New York State A. of Public Health Laboratories, 1205
New York State Charities Aid A., 1054
New York Surg. S., 981
New York Tuberculosis A., 134
New York, Women's M. S. of, 899, 1451
North America, Cong. of French-Speaking Phys. of, 726
North America, Radiological S. of, 481, 896
North Carolina, M. S. of the State of, 1369, 1558
North Carolina Tuberculosis A., 1369
North Dakota State M. A., 1370
Northeast Colorado M. S., 799
Northeastern Indiana Acad. of M., 1869
North Idaho District M. S., 133
North Pacific Surg. A., 218
North Texas M. A., 135
Northumberland County (Ont.) M. A., 1978
Northwest Central (Iowa) M. S., 133
Northwestern Michigan Clinical S., 40
Ohio Dietetic A., 1701
Ohio Hosp. A., 1701
Ohio State M. A., 310, 1789
Oklahoma State M. A., 1789
Ontario Health Officers' A., 1371, 1790
Ontario M. A., 726
Oregon State M. S., 1618, 2058
Oregon Tuberculosis A., 898
Pacific Northwest M. A., 401
Pan-American Red Cross Conf., 137, 1060
Pan-American Scientific Cong., 982, 2059
Panhandle M. S., 1452
Paris (France) Acad. of M., 220
Paris, Am. M. of, 1703
Pennsylvania, Hosp. A. of, 1790
Pennsylvania, Public Charities A. of, 311
Pennsylvania State Conf. on Social Work, 640
Pennsylvania Tuberculosis S., 479
Peruvian M. A., 137
Phi Beta Pi Fraternity, 219
Philadelphia Acad. of Surg., 981
Philadelphia A. for the Prevention and Relief of Heart Disease, 1451
Philadelphia Clinical A., 640
Philadelphia Clinical Pathological A., 640
Philadelphia County M. S., 1451, 1701, 2058
Philadelphia Laryngological S., 725
Philadelphia Nat. M. Cong., 1054
Philadelphia Neurological S., 640
Philadelphia, Obstetrical S. of, 725, 1273
Philadelphia Pathological S., 725
Philadelphia, Pediatric S. of, 640, 1790
Philadelphia Psychiatric S., 1790
Philippine Islands M. A., 480
Porto Rico, M. A. of, 218
Puget Sound Acad. of Ophthalmology and Oto-Laryngology, 556
Queen's County (N. Y.) M. S., 134
Rhode Island M. S., 2058
Rock Island County (Ill.) M. S., 1272, 1616
Royal Institute of Public Health, 1132, 1561
Royal Sanitary Institute, 137
Royal S. of M., 137, 1208, 1792
Sacramento (Calif.) S. for M. Improvement, 722
Salt Lake County M. S., 311
San Francisco Bay Counties Hosp. A., 38
San Francisco County M. S., 722
Santa Barbara County (Calif.) M. S., 723
Saskatchewan M. A., 480
Seaboard (Va.) M. S., 311
Seattle Surg. S., 400
Seattle Urological S., 1206
Sioux Valley Eye and Ear Acad., 398
S. for Experimental Biology and M., 1619
S. for the Prevention and Relief of Tuberculosis, 1700
South African M. Cong., 402
South Carolina M. A., 726, 1451
South Carolina Public Health A., 1558
South Dakota State M. A., 1872
Southern California M. A., 1276
Southern M. A., 234
Southern Minnesota M. A., 1276
Southern Public Health Laboratory A., 1128
South Texas District M. A., 1450
Southwestern Kentucky M. A., 1788
Spanish-American League, 1376
Spanish Cong. on M. Hydrology, 1877
Spanish-Latin American Specialists' Cong., 1276
State Charities Aid A., 1617
St. Louis M. S., 554, 1204
Swedish M. A., 43
Tennessee Anti-Tuberculosis A., 1872
Tennessee State M. A., 1368, 1452
Texas Public Health A., 802
Texas, State M. A. of, 1358
Texas Surg. S., 1452
Tri-State District M. A., 556, 1207
Tri-State M. A., (Mich., Ohio and Ind.), 1207, 1452
Tri-State M. A., (Va., N. and S. Carolina), 803
U. S. and Canada, Associated Anesthetists of the, 896
Utah State M. A., 1274
Virginia Conf. of State Health Workers, 899
Virginia Public Health A., 1702
Virginia Tuberculosis A., 802
Walter Reed M. S., 1274, 1790
The Wapiya, 1449
Washington M. and Surg. S., 1615
Washington Psychanalysts S., 1368
Wayne County (Mich.) M. S., 638
West Virginia State M. A., 1872
Western Electro-Therapeutic A., 554
Western Pennsylvania M. Officers' A., 41
Western Physiotherapy A., 1703
Western Surg. A., 237
Wisconsin, State M. S. of, 1559
Women's Nat. M. A., 478, 1272
Wyoming State M. S., 1371

T

TABES DORSALIS, beginning tabes, [Wittgenstein] 1233—ab
early diagnosis of, [Lafora] 2090—ab
experimental, [Buschke & Kroó] 343—ab
gastro-intestinal hemorrhage in, [Poliakoff] 1576—ab
waves of aggravation in course of, [Foix & Lagrange] 1653—ab
TACHYCARDIA, paroxysmal, possibility of surgical treatment of, [Leriche] 1230—ab
paroxysmal, quinidin in, [Musser] 820—ab
ventricular, during auricular tachycardia, [Barker] 1896—ab
ventricular ectopic, [Reid] 655—ab
ventricular, ventricular fibrillation following, [Reid] 1815—ab
TALIPES: See Foot, deformities
TARTAR EMETIC, cumulative action of, [Brahmachari] 161—ab
in treatment of nonvenereal ulcers, [Pereira] 1150—ab
multiple poisoning with, [Lehmann] 831—ab
TATTOOING and sexual perversions, [Dupouy & Minkowski] 1083—ab
TAURINE, substituting, for cystine does not retard growth, [Mitchell] 1733—ab
TAXATION, Finance Committee refuses reduction in medical taxes 1207
gift tax struck from bill, 1275
medical interest in tax revision, 128—E
Mellon Tax Bill, 44
no reduction in special physicians' taxes, 889—E
physician's income tax, 230—ME
reduction of income tax, 1873
surgeon's tax grievance, 902
tax reduction week, 1126—E
treasury and physicians, 2132
why medical profession should be relieved from present tax burdens, 326—ME
TEETH and diet, 1611—E
crumbling teeth, 1984
identification by, 1623

TEETH, infected, elective localization in eye of bacteria from teeth, [Haden] 417—ab
infected, eye inflammations caused by dental sepsis, [Jones] 63—ab
influence of diet on, [Toverud] 578—ab
irradiation as possible treatment of root "abscess," [Bloodgood] 1882—C
polyarthritis after pains in, [Troisier & others] 661—ab
TELEGRAPHY, wireless, dangers of, [Axmann] 1825—ab
TELEPHONES, public, and disease, 728
service, special medical, 412
TEMPERATURES, comparative value of mouth and rectal temperature, [Bendes & others] 63—ab
endocrine factor in chemical control of, [Cannon] 1725—ab
high, effect of, on man, [Adolph & Fulton] 997—ab; 1719
TENDONS, primary suture of, [Porges] 1486—ab
rupture of, [Odermatt] 165—ab
transplants, [Katzenstein] 666—ab
TENIA saginata in China, [Mills] 337—ab
treatment, duodenal tube in treatment of, [Schneider] 1659—ab
TERATOMA, sacral, in new-born excised, [Cutler] 499—ab
genesis of, [Budde] 2149—ab
TERSUL HILLER not accepted for N. N. R., 1712—P
TEST TUBES, defects in, as cause of anomalous reactions, [Lyon] *1863
TESTES, atrophy of, basal metabolism in, [Harvier & Van Bogaert] 1573—ab
ectopia pubopenilis, [Moynihan] 1399—ab
ectopic, complications of, [Navarro] 250—ab
effect of vasectomy on, [Oslund] 496—ab
grafting of, [Walker] 1082—ab
internal secretion of, [Walker] 583—ab
physiology of, [Ocaranza] 828—ab
scrotum as temperature regulator for, [Moore & Quick] 1391—ab
trophic innervation of, [Lipschütz & Voss] 1085—ab
tuberculosis of, [Schoonover] 1228—ab
tumor, malignant, in undescended testis, [Lund] 1394—ab
tumors of, [Hinman & others] 998—ab
tumors of, malignant, in children, [Kutzmann & Gibson] 576—ab
tumors, pathology of, [Southam & Linell] 63—ab
undescended, [Mixter] 235—ab
undescended, malignant tumor in, [Lund] 1394—ab
undescended, treatment of, [Bonem] 1157—ab
TESTIMONY as to defendant having venereal disease, 1806—MI
expert, 915—MI
expert evidence; privileged communications; physician may testify nonprofessionally, 818—MI
expert when it cannot be disregarded, 330—MI
inquiring as to agreeing to physician testifying—privilege not waived, 1070—MI
of attendant, 233—MI
questions and cross-examination for one not alienist, 154—MI
when one may testify as to observations—testimony of distinguished alienist, 1142—MI
TETANUS Antitoxin, 1047
antitoxin, production of, [Kraus] 666—ab
as complication in drug inebriety, [Doane] *1105
experimental, protein shock in, [Arloing & Thévenot] 1230—ab
kyphosis from, [Wilhelm] 67—ab
of new-born, [Bratusch-Marrain] 1404—ab
of new-born, treatment of, [Bratusch-Marrain] 345—ab
paralysis after serum treatment of, [Hermitte] 1402—ab
phenol and antitoxin in, [Beall] 1993—ab
TETANY: See also Spasmophilia
TETANY, [de Levie] 668—ab, [Thompson] 1811—ab
alkalosis, sodium poisoning and, [Greenwald] 1224—ab
and alkalosis, [Adlersberg & Porges] 168—ab, [Zehnter & Foncin] 1004—ab
and diabetes, [Motsfeldt] 74—ab
and spasmophilia, 813
blood serum calcium and protein in, [Salvesen & Linder] 578—ab
discarded theory of, 1785—E
infantile, and ultraviolet rays, 1375
innervation of spasms in, [Freudenberg & Läwen] 252—ab
not due to guanidine intoxication, [Greenwald] 1816—ab
parathyroid, action of calcium in, [Blumenstock & Luckhardt] 997—ab
pathogenesis and treatment of, [Scheer & Salomon] 168—ab
postoperative, [Melchior & Nothmann] 169—ab, [Syring] 1487—ab
postoperative, implantation of parathyroid glands from horse in treatment of, [Krecke] 757—ab
TETANY, spasms due to autonomous nerves, [Grosszmann] 2149—ab
TETRABROMPHENOLPHTHALEIN TEST: See Gallbladder
THALAMUS, relation of, to heat production, [Rogers & Lackey] 135—ab
THALLIUM rickets in rats, [Buschke & others] 1485—ab
THEATER, physicians as represented on stage, 484
THERAPEUTICS, animal poisons, [Flury] 252—ab
integral, [Pulido] 2090—ab
physiocracy versus anthropocracy, [Rieger] 1405—ab
recent progress in, [Lyon] 1401—ab
THERMOMETER bill, 219
THIOSULPHATE, sodium, antidote for arsenic, bismuth and mercury poisoning, [Semon] 1815—ab
THORACOPLASTY: See also under Tuberculosis, Pulmonary
THORACOPLASTY, graded extrapleural, for bronchiectasis, [Hedbiom] 823—ab
paravertebral, [Josetti] 929—ab
THORAX, roentgen study, value of lateral projection in, [LeWald & Green] 823—ab
intrathoracic tumors, [Heuer] 2080—ab
pulsating abscess of, simulating aneurysm, [Kahn] *1933
wound, valvular thoracotomy for, [Connell] 1992—ab
wounds, sequelae of, [Brelet] 661—ab
THROAT infections, laboratory diagnosis in, [Young & Crooks] 1298—ab
normal, hemophilic bacteria of, [Dible] 1734—ab
syphilitic sore throat following tonsillectomy, [Howe & Schmidt] 1299—ab
THROMBO-ANGIITIS obliterans, [Christianson] 1649—ab, [Gleckler] 1993—ab
THROMBOPENIA: See Blood platelets
THROMBOPHLEBITIS, metastatic cerebral, [Eppler] 1299—ab
progressive, of splenic, portal and hepatic veins, [Warthin] 1808—ab
septic, of femoral vein, [Pool & McGowan] 2080—ab
THROMBOSIS and embolism resulting from renal tumors, [Judd & Scholl] *75
after childbirth, [Schmid] 1826—ab
coronary, simulating perforated peptic ulcer, [Hart] *692
of axillary vein; anatomic study, [Lowenstein] *854
of central retinal vein and its branches, [Greenwood] *92
of internal jugular vein, [Rouget] 927—ab
THRUSH: See also Oidium albicans
THRUSH, [Epstein] 1307—ab
many fungi cause thrush, [Castellani] 1480—ab
THYMOL and carvacrol, vermicidal action of, [Caius & Mhaskar] 161—ab
THYMUS, enlarged, [Parsons] 1396—ab
enlarged, evidence in case of death under anesthetic, 1566—MI
enlarged in goiter, [Glordano] 157—ab
enlarged, in infants, [Barnett] 159—ab
enlarged, not cause of death, [Smith] 159—ab
enlarged, roentgenotherapy for, [Spohn] 159—ab
persistent, in exophthalmic goiter, [Frassi] 341—ab
roentgen treatment, [Merlo Gómez] 1574—ab
THYROID: See also Goiter; Hyperthyroidism
THYROID activity and basal metabolism, 569
aberrant tissue of, in trachea, [Schachenmann] 2149—ab
and dermatitis herpetiformis, [Rost] 588—ab
cancer, latent, metastasis in bone of, [Niny Silva] 426—ab
disease, cardiac disturbances associated with, [Wilson] *1754
disease, familial dysthyroidism, [Etienne & Richard] 1656—ab
disease, radium therapy of, [Bower & Clark] 240—ab
effect of feeding thyroid on growth, [Terao & Wakamori] 1734—ab
extract, dosage of, 2070
function of, in development of chick, [Willier] 1569
function tests, Kottman reaction in insane, [Saunders] 1298—ab
in young children, [Figueras] 1999—ab
influence of, on increased heat production during lactation and pregnancy, [Marine] 1726—ab
injury of, [Schwoerer] 1739—ab
insufficiency, [Josefson] 234—ab
roentgenization of, [Fraenkel] 829—ab
skin changes of, thyroid origin, [Bogroff & Krupnikoff] 1824—ab
surgery, accidents in, [Pfanner] 1089—ab
tissue, oxygen test of, [Hara] 169—ab
treatment, [Curschmann] 665—ab
THYROIDECTOMY, effect of, on development, [Hammett] 351—ab
effect of, on blood serum calcium, [Rabinowitch] 2083—ab
further modification in technic, [Roeder] *517
mortality of, [Fahrni] 1147—ab
THYROIDECTOMY, offspring of thyroidectomized animals, [Parhon & Marza] 1152—ab
subtotal, effect of, in toxic goiter, [Segall & Means] 822—ab
THYROXIN, diuretic action of, [Hildebrandt] 1007—ab
TIBIA, localized periosteal sarcoma of, [Attix] 237—ab
TIC douloureux: See Neuralgia, trigeminal
nasal polyps, sinusitis and tic, [Hubbard] 1732—ab
TINEA of scalp, [Pardo Castelló] 1998—ab
TINNITUS AURIUM with high blood pressure, [Wharry] 1897—ab
TISSUE, cultivation of, in saline embryonic juice, [Pannett & Compton] 1151—ab
culture, survival and growth of fibroblasts in vitro, [Carrel & Ebeling] 61—ab
Granulation: See Wounds
growth and cell crowding, [Fischer] 335—ab
growth in vitro, action of metal ions on, [Mendéléeff] 1898—ab
growth in vivo, placenta in genesis of embryonal tissues, [Mendéléeff] 1898—ab
respiration of, [Ahlgren] 1826—ab
TOBACCO, antitobacco campaign in Austria by physicians, 1281
amblyopia, [Adrogué] 69—ab
damages for illness from chewing snake in, 1806—MI
nicotin and duodenal syndrome, [Wagner] 1903—ab
TOLYSIN omitted from N. N. R., 1381—P
TONGUE, epithelial hyperplasia of, [Fordyce & Cannon] 821—ab
fissured, 1139
TONSIL, chancre of, [Ramadier] 927—ab
diseased, radiologic treatment of, [Hunter] 1650—ab
enlarged, roentgenotherapy of, [Piga & others] 167—ab
epithelioma of, [Smith] 1227—ab
extirpated, bacteriology of, [Nakamura] 821—ab
infected, cause mental symptoms, [Shaw] 998—ab
infected, enlarged lymph glands diagnostic of, 875—ab
infected, tonsillar and rheumatic infections, 57
pathophysiology of, [Goerke] 930—ab
tuberculosis of, [MacCready & Crowe] 917—ab
TONSILLECTOMY, aspiration of tonsil during, [Lendon & Pulleine] 338—ab
cause of failure of, [Wharry] 1651—ab
in its relation to recurrence of rheumatism, [Ingerman & Wilson] *759
in treatment of optic neuritis, [Poppi] 828—ab
local anesthesia in, 1287
results of, in acute rheumatism in children, 231—ME
return of tonsil after, [Bilancioni] 586—ab
subcutaneous emphysema following, [Rosenbaum] *2119
syphilitic sore throat following tonsillectomy, [Howe & Schmidt] 1299—ab
TONSILLITIS, acute, hemolytic streptococci in, [Felty & Bloomfield] 157—ab
albuminuria with, [Josel] 1650—ab
chronic, treatment of, [Daland] 746—ab
spread by intensive crowding, [Bloomfield & Felty] 157—ab
transmission of, [Bloomfield & Felty] 1730—ab
TORSION SPASM, progressive, [Lopez Albo] 341—ab
TORTICOLLIS, mental, and striatal syndrome, [Long] 1305—ab
TORULA infection in man, [Sheppe] 745—ab, [Hansmann] 2145—ab
TOXEMIA, intestinal, etiologic importance of, [Eustis] 749—ab
acute, choroid plexus in, [Siengalewicz] 1152—ab
alimentary intoxication, [Kleinschmidt] 167—ab
toxicoses from devitalized tissue, [Peyrer] 429—ab
TRACHEA, chronic stenosis of larynx or, [Klaue] 343—ab
aberrant thyroid tissue in, [Schachenmann] 2149—ab
cicatrical stenosis of, Keen operation for, [Jackson & Keen] *2027
TRACHEITIS, [Köhler] 1089—ab
TRACHEOTOMY for laryngeal diphtheria, fatal hemorrhage following, [Schlaepfer] *1581
TRACHOMA, 1210, 1707
treatment of, [Nicati] 661—ab
TRANSFUSION: See Blood transfusion
TRANSPLANTATION: See also Bone grafts; Ovary grafts, etc.
TRANSPLANTATION, survival of transplanted organs, 393—E
successful homoplastic grafts, [Epstein] 1997—ab
TRAPEZIUS muscle, treatment of paralysis of, by myoplasty, [Eden] 1825—ab
TRAUMA, late effects of, [Christiansen] 1083—ab

TREMOR, registration of, [Stenström] 1406—ab
TREPHINING, decompressive, and puncture of ventricle, [Barré & Morin] 164—ab
  future of the trephined, [Weitzel] 67—ab
TREPHONES, leukocytic, [Carrel] *255
TREVES, SIR FREDERICK, 45
TRICHINOSIS, neo-arsphenamin in treatment of, [Algora y Nieto] 1232—ab
TRICHOMONAS, infestation with, 1864—E
TROPHEDEMA, [Léri & Péron] 661—ab
TROPICAL DISEASES, Ross Institute for, 728
TROPICS, influence of, on man, [Eijkman] 1896—ab
TRYPANOSOMIASIS, cutaneous chemotherapy, [Funco] 827—ab
  of mice and "Bayer 205," [Morgenroth & Freund] 665—ab
  prophylaxis against, in Congo, 318
  spontaneous, in monkeys, [Chagas] 1822—ab
  testing "Bayer 205" in Africa, [Kleine] 1575—ab
TRYPARSAMIDE; its action and use, [Brown & Pearce] *85
  arsenic content of blood after, [Fordyce & others] 1813—ab
  visual disturbances produced by, [Woods & Moore] *2105
TRYPSIN, flocculation of, [Saxl] 428—ab
  action of, on insulin, [Epstein & Rosenthal] 1990—ab
TSUTSUGAMUSHI DISEASE, rickettsia-like organism in, [Sellards] 332—ab
TUBERCLE BACILLI, action of iron on growth of, [Frouin & Guillaumie] 1821—ab
  concentration of, [Andrus & MacMahon] 1814—ab
  cultivation of, [Löwenstein] 1308—ab, [Cancik & Mazepová] 1660—ab
  demonstration of, [Victor] 334—ab
  differential biologic test of type of human and bovine tubercle bacilli, [Schilling & Hackenthal] 2148—ab
  effect of carbon on, [Corper & others]1144—ab
  elimination of, by kidneys, [Hobbs] 247—ab, 423—ab
  erythema nodosum with tuberculous bacillemia, [Watt & Stubbs] 1301—ab
  filtered, return to type of, [Dunrand & Vaudremer] 1898—ab
  filtration of, [Veltis] 826—ab
  in bile, [Corper & others] 333—ab
  metabolism of, [Braun & Kondo] 588—ab
  types of, isolated from animals, [Soparkar] 1651—ab
  virulence and toxicity of, [Borrel & others] 562—ab
  Weleminsky's tuberculomucin, [Sichan] 831—ab
"TUBERCULAR" surgery of spine and extremities, [Taylor] 1381—C
TUBERCULID, papulonecrotic, etiology of, [Guy] 821—ab
TUBERCULIN, action of, [Adler] 176—ab
  allergy and whooping cough, [Galli] 165—ab
  in diagnosis and treatment; [Philip] 1229—ab
  reaction, [Marfan] 1004—ab
  reaction and vegetative system, [Moro] 428—ab
  reaction and vitamins, [Prausnitz & Schilf] 828—ab
  reaction in rabbit, [Coulaud] 826—ab
  reaction, skin, and immunity to tuberculosis, [Marfan] 1823—ab
  reaction, skin, in glandular disease, [Générvrier] 662—ab
  test, cutaneous, [Cummins] 1001—ab
  Treatment: See under Tuberculosis
TUBERCULOSIS: See also under names of various organs, as Kidney, tuberculosis of
TUBERCULOSIS, active, inactive and latent, [Stocker] 750—ab
  a metastasizing infection, [Krause] 1814—ab
  after-care of tuberculous patients, 314
  agglutination of Malta fever cocci in, [Amabile] 1205—ab
  agglutinins of, in animals, [Cioffi] 1823—ab
  analysis of histories of tuberculous invalid pensioners, [Holmes & Kerr] 2086—ab
  and alcoholism, [Samson] 2091—ab
  and branchiogenous glands, [Hoffmann] 506—ab
  and goiter, [Hoffmann] 252—ab
  and neurasthenia, [Tardieu] 1654—ab
  and nutrition, [Seiler] 1902—ab
  and syphilis, [Bowman] 338—ab, [Samson] 666—ab
  and the army, 404
  and trauma, [Poiettini] 663—ab, [Farmer] 923—ab
  and whooping cough, [Koenigsberger & Fuerst] 1008—ab
  associated infections in, [Courmont & Bolssel] 622—ab
  Austrian Antituberculosis Society, meeting of, 2063
  autoserum reaction in, [Forleo] 425—ab, [Henrichsen & Sweany] 576—ab, [Ornstein] 576—ab
  Bacilli: See Tubercle Bacilli
  blood, chemistry of, [Sweany & others] 820—ab
TUBERCULOSIS, blood counts in, [Zee-Whay] 1234—ab
  blood in, hemogram in tuberculosis, [Dornedden] 2148—ab
  blood picture in, effect of drugs on, [Bender & de Witt] 1392—ab
  blood sedimentation test and tuberculin treatment, [Stukowski] 1487—ab
  blood sedimentation test in, [Raykowski] 1309—ab
  blood serum, agglutination of Flexner bacillus by, [Hull & Henkes] 333—ab
  blood serum calcium values in, [Barkus] 1392—ab
  bovine, and rabies in Dutch East Indies, 2133
  bovine, in India, [Liston & Soparkar] 1651—ab
  calcium inhalation prevents, [Tweddel] 1079—ab
  cause of fatty infiltration of liver in, [Goldberg] 333—ab
  control, [Horwood] 998—ab, [Böhm & Götzl] 1156—ab; 1210, [Kayser-Peterson] 1308—ab
  control among Vienna children, 1768
  control in England, [McNalty] 825—ab
  cross fixation of syphilitic antigen by tuberculous serums, [Kilduffe] 158—ab
  cutireaction and immunity against, [Marfan] 425—ab
  disseminated, [Carlson] 1477—ab
  disturbances of urination in, [Kováts] 667—ab
  Dreyer vaccine, failure of, 1278
  Dreyer vaccine in, criteria for cure in tuberculosis, [Kettle] 751—ab
  effect of foreign protein on, [Freed] 1145—ab
  Ellis test for, [Ferguson] 749—ab
  experimental, and vitamins, [Leichtentritt] 2148—ab
  experimental, conjunctival instillation of tubercle bacilli causes infection, [Cummins] 585—ab
  experimental studies on tuberculous infection and reinfection, [Krause & Willis] 1800—ab
  fat and urobilin in stools in, [Friedrich] 2091—ab
  Fornet's reagent, [Salus] 1308—ab
  fusiform bacilli and spirochetes cause secondary infection in, [Pilot & others] 333—ab
  gummatous form of, [Lemierre & Kindberg] 1821—ab
  heliotherapy in, [Bollier] 1144—ab
  human, beginnings of, [Debré & Laplane] 927—ab
  immunity, [Arima & others] 2148—ab
  immunity to, and skin tuberculin reaction, [Marfan] 1823—ab
  in Belgian Congo, 2132
  in children, blood in prognosis of, [Gulden & Ehlers] 1657—ab
  in children, cutireaction in diagnosis of, [Marfan] 341—ab
  in children, pulmonary versus extrapulmonary, [Ghon & Winternitz] 1743—ab
  in children, tuberculous and pretuberculous child, [Simpson] 1151—ab
  in ex-service men; government provision for, 729
  in Germany, increase in incidence of, 142
  in guinea-pigs, [Klopstock] 427—ab
  in infant, [Capon] 750—ab
  in infants, prognosis of, [Hahlo] 1657—ab
  in Luxemburg, 317
  increase of, where tuberculosis is increasing, 2123—E
  influence of allergic rhinitis on, [Kahn] 1392—ab
  Laryngeal: See Larynx, tuberculosis of
  latent, diagnosis of, [de Michele] 1006—ab
  light energy in, [Balderrey & Ewald] 1144—ab
  liver function in, [de Martini] 928—ab
  local, effect of circulatory constriction on, [Corper & Goldberg] 1144—ab
  miliary, healed, [Baer] 917—ab
  mortality, decline of, 573
  mortality in Colorado, 535—ab
  mortality in France, 1561
  mortality in last 4 years, 1281
  mortality in 1922 in U. S. registration area, 1266—ab
  need for more teaching of, [Young] 1151—ab
  nonspecific reactions in, [Petschacher] 345—ab
  notifiable in England and Wales, 1602—ab
  pericostal, [Ito] 2092—ab
  problems of, [Igersheimer] 1826—ab
  protest against "healers" of, 316
  reliable auscultatory signs in, [Heise] 333—ab
  sanatorium, a French Saranac, 1132
  sanatoriums, 987
  sanatoriums, closing of, 1282
  serodiagnosis of, [Mündel] 931—ab, [Krömeke] 1155—ab, [Blumenthal] 2148—ab
  serodiagnosis, Besredka's tuberculosis reaction, [Trenti] 1656—ab, [Fried] 1814—ab
  serodiagnosis, complement fixation test for, [Kilduffe] 1814—ab, [Sasano] 1814—ab, [Hansen & Wurtzen] 1904—ab
TUBERCULOSIS, serodiagnosis, fixation reaction in tuberculosis, [Hurmuzachi & Nicodim] 1401—ab
  serodiagnosis, Mátéfy reaction, [Basch] 1575—ab
  serodiagnosis, Wassermann's tuberculosis reaction, [Jansen] 74—ab
  simulation of, [Bruté & others] 423—ab
  size of primary tuberculous focus, [Ghon & Reymann] 73—ab
  specialists in Czechoslovakia, 1377
  specialists visit France, 1134
  surgical, general iodin treatment of, [Gregory] 757—ab, [Hotz] 2094—ab
  surgical, periarterial sympathectomy in, [Läwen] 1156—ab, [Gundermann] 1156—ab
  surgical, seaside sanatoriums for, 486
  surgical, treatment of, [Zahradnický] 2094—ab
  surgical, treatment of bone and joint tuberculosis, [Thornton] 1811—ab
  transmission, eggs and tuberculosis, 1985
  treatment, [Wright] 925—ab
  treatment, action of antigen on serum of tuberculous children, [Armand-Delille & others] 1898—ab
  treatment, artificial light therapy in, [Mayer] *1920
  treatment in German sanatoriums, 1453
  treatment, influence of silica on, [Maver & Wells] 576—ab; 1610—E
  treatment of colds in tuberculous subjects, [Gunter] 1399—ab
  treatment of constipation in, [Spector & Larimore] 1145—ab
  treatment, principles of immunity in, [Gloyne] 1735—ab
  treatment, sodium morrhuate in, [Boelke] 581—ab, 813
  treatment, use of convalescent serum in, 1565
  treatment, value of organic mercurial compounds in, [DeWitt] 333—ab
  tuberculin allergy and problem of tuberculous constitution, [Bezançon] 1005—ab
  tuberculin treatment of, [Taylor] 63—ab, [Philip] 1229—ab
  tuberculin treatment, Gabrilovitch tuberculin, 1279
  urine in, [Reinwein] 1825—ab
  vaccination by Martinotti method, 317
  vaccination, preventive, [Vacarezza] 505—ab
  vaccine of Pozndorf cutaneous antituberculosis vaccine, 317
  Wassermann's tuberculosis reaction, [Jacob & Moeckel] 1999—ab, [Silberstein] 2148—ab
  Widal test in, [Hull & Henkes] 333—ab
  work colonies for the tuberculous, 803
TUBERCULOSIS, PULMONARY, adolescent tubercle, [Woodcock] 247—ab
  anisocoria in, [Fanelli] 165—ab, [Alterthum] 1232—ab
  auscultation in, 2016—ab
  blood cell volume in, [Schlomovitz & others] *1845
  blood lipase in, [Woolley] 1392—ab
  chronic appendicitis simulating, [Torres] 1574—ab
  classification of cases, [Cummins] 1733—ab
  complications of, [Jacquemin] 2087—ab
  concurrent occurrence of, and asthma, [Ezekiel] 658—ab
  contagiousness of, [Zadek] 251—ab
  diagnosis, D'Espine's sign in hilum tuberculosis, [Carroll & Gibson] 1146—ab
  diagnosis from early signs, [Goudman-Benstz] 1406—ab
  evolution of, [Paraf] 239—ab
  exogenous reinfection, [Ballin] 345—ab
  fissural limitations of, [Sergent & Durand] 662—ab
  in miners, 1794
  influence of mediastinal displacement on, [Hislop] 338—ab
  menstrual reaction in, [Maendl] 2093—ab
  miliary, [Blaine] 1391—ab
  miliary, chronic, [Burnand & Sayé] 2148—ab
  mode of infection in, [Cornet] 61—ab
  neutrophil leukocytes in, [Stephani-Montana & Stephani-Montana] 1232—ab
  pseudo-tuberculosis, [Caputi] 165—ab
  reflexes in, [Pottenger] 1079—ab
  respiratory function in, [Piery & Boisseau] 247—ab
  serology in, [Katz & Rabinowitsch-Kempner] 74—ab
  surgical treatment, [Gravesen] 590—ab, 1118—ab, [Young] 1399—ab, [Sant'Anna] 1403—ab
  surgical treatment, artificial pneumothorax therapy, [Burnand] 1482—ab, [Rolleston] 1735—ab
  surgical treatment, phrenicotomy, [Landé] 1743—ab, [Lehmann] 1744—ab
  surgical treatment, plugging lung with fat tissue, [Stoenstrup] 1488—ab
  treatment by artificial heliotherapy, [Fecht] 829—ab
  treatment by "ventralization," [Signorelli] 1231—ab
  treatment, intrapleural pneumolysis; thoracoplasty, [Kloesser & Brown] 1144—ab
  tuberculous cavitation of lung, [Gekler & others] *457
  work in, [Borgherini-Scarabellin] 1006—ab

VITAMIN C, test for, [Koopman] 346—ab
content of grapefruit, [Morgan & Chaney] 1883—ab
deficiency disorders, pathogenesis of, 1124—E
experimental, and tuberculosis, [Leichtentritt] 2148—ab
fate of, in body, 1867—E
in deficient diets, effects of, [Gross] 824—ab
in garden soil, [McCarrison] 161—ab
in Milk: See Milk, vitamins in
inactivation of, in infants, [Erderer & Kramár] 343—ab
lactation and lack of, [Eckstein & Szily] 588—ab
loss of, from body by excretion, 1270—E
necessity for, [Cramer] 1480—ab
VITA-PEP, another wet spot in the national desert, 907—P
VITILIGO, extensive, [Archibald] 582—ab
VIVISECTION: See Animal Experimentation
VOCAL CORDS, valve function of, [Negus] 582—ab
von VOLKMANN, death, of 325
VOLSTEAD ACT: See Prohibition
VOLVULUS of entire small intestine, [Wheeler] 919—ab
torsion, of right colon, [Twyman] 238—ab
VOMITING: See also under Pregnancy
VOMITING, cyclic, in children, sodium bicarbonate for, [Fismer] 661—ab
habitual, in nurslings, [Berro] 2089—ab
in infants, atonic insufficiency of stomach causes, [Lindberg] 1223—ab
postoperative, prophylaxis of, [Blondel] 248 ab, [Bohne] 506—ab
VULVA, carcinoma of fourchette, [Brady] 334—ab
VULVOVAGINITIS, mercurochrome in, [Dorne & Stein] 1298—ab

W

WAR: See Army; Rehabilitation; Soldiers; Veterans
WART: See Verruca
WASSERMANN REACTION, 1066
and clinical histories, [Felson & Christina] 1076—ab
and contagiousness, [Stern] 664—ab
and Kolmer tests, [Irvine & Stern] 822—ab
and Meinecke tests, comparative value of, [McGlumphy] 1731—ab
and treatment of syphilis, 1383
criterion of cure, [Belding] 1077—ab
in cerebrospinal fluid; tumors and Wassermann reaction, [Weil & Weissmann-Netter] 248—ab
in diabetes mellitus, [Rockwood & Sanford] 241—ab
in different social classes, [Belding & Hunter] 1076—ab
influence of pregnancy on, [Browne] 924—ab
insulin does not affect, [Kretschmer] 1731—ab
nonspecific, 264—ab
WASSERMANN REACTION, reactivation of, [Spremolla] 1656—ab
standard technic for, [Ruediger] 820—ab
theory of, [Griesbach] 2093—ab
with dried blood, [Chapman] 1890—ab
WATER exchange and heat regulation, 1200—E
analysis, standard methods of, 2059
Mineral: See Mineral Waters
WEATHER: See also Climate
WEATHER, cause of sultriness, [Griesbach] 830—ab
WEIGHT-HEIGHT-AGE TABLES, use and abuse of, as indexes of health and nutrition, [Baldwin] *1
WEIGNER'S fiftieth birthday, 2133
WEIL-FELIX REACTION in typhus, [Altounyan] 751—ab
positive, value of, [Maxcy & Havens] 332—ab
WEIL'S DISEASE: See Jaundice, spirochetal
WERNER SIEMENS INSTITUTE for Roentgenographic Research, 1282, 1378
WHEAT, poisonous, [Swarup] 2086—ab
WHITE LINE, sympathetic tonus in mumps, [Benard] 163—ab
white dermographia, [Sézary & Dessaint] 163—ab
WHITTINGTON'S CONSUMPTION CURE a fraud, 1983—P
WHOLE OVARY-LEDERLE, 391
WHOOPING COUGH and tuberculin allergy, [Galli] 165—ab
and tuberculosis, [Koenigsberger & Fuerst] 1008—ab
preventive center against, [Debré & others] 1303—ab
protein treatment in, [Macciotta] 1232—ab
roentgenotherapy in, [Leonard] 1391—ab, [Bowditch] *1422
treatment of, [Galli] 68—ab, [Henske] 579—ab
treatment with ether, [Drake] 1818—ab
WIDAL REACTION, macroscopic, [Arguelles] 580—ab
in tuberculosis, [Hull & Henkes] 333—ab
misleading serologic tests, [Burghi] 68—ab
WILL, opinions as to mental condition—from handwriting, 744—MI
"sound mind" for purpose of making will, 744—MI
WILSON'S DISEASE in infancy, [Paul] 1404—ab
and Westphal-Strümpell's pseudosclerosis, [Sahlgren] 832—ab
WIRSUNG'S DUCT: See Pancreatic Ducts
WITNESS, may support expert witness aggressively attacked, 996—MI
WOLF, mad, ravages of, 2134
WOLFFIAN BODY, cyst of, [Hinman & others] 2080—ab
WOMEN, rights of, guardianship of infants bill, 1456
what is law for man is also law for woman, 154—MI
WORKMEN'S COMPENSATION, "loss of bodily function," 1720—MI
WORKMEN'S COMPENSATION, death from pneumonia after inhalation of gas, 58—MI
"disfigurement" defined—when compensation is allowed, 1222—MI
injured employee contracting typhoid in hospital, 1294—MI
intern an "employee" within compensation act, 915—MI
justified seeking proper treatment, 1141—MI
loss of eye affording only perception of light, 234—MI
need not submit to operation to correct bad union of fractured femur, 1466—MI
total disability notwithstanding some earning power, 1386—MI
WOUND: See also under names of organs and regions
WOUND, abdominal, spontaneous rupture of, [Danzis] *876
effect of abscess on distant aseptic cicatrization, [Carrel] 1230—ab
noninfected, general reactions during healing of fractures and, [Löhr] 343—ab
severe stab, recovery from, [Hefferman] 1002—ab
treatment of—evidence of negligence, 2144—MI
vital staining of, [Gaza] 2092—ab
WRITERS' CRAMP, device for relief of, [Sayre] *1691
WRITING, opinions as to mental condition—from handwriting, 744—MI

X

XANTHIN compounds and vegetative system, [Backman] 926—ab
XANTHOMA of eyelid, [Nobl] 344—ab
tuberosum, [Weidman & Freeman] 1145—ab
XEROPHTHALMIA and low protein diet, [Hejinian] 997—ab
and vegetables, [Blegvad] 1904—ab
treatment of, [Blegvad] 430—ab
why it deserves attention, 1048—E

Y

"YALE ANALYSIS BUREAU," 1632
YEAST, brewer's, substitute for insulin, [González Rincones & Noguera Gómez] 166—ab
YELLOW FEVER, bacteriologic diagnosis of, [M'Cormick] 250—ab
Pfeiffer reaction in, [Noguchi] 1391—ab; 1521—E
YOHIMBIN, toxicity of, [Raymond-Hamet] 1152—ab
YOUNG, THOMAS, (1773-1829), physician and scientist, [Hooker] *55

Z

ZINC stearate baby powders, reports wanted on accidents from, 475
ZINC-BOROCYL, 1713—P
ZUCKERKANDL, statute of, 1708

AUTHOR INDEX

In this Index are the names of the authors of articles which have appeared in THE JOURNAL, the names of those who have read papers before Societies as published in THE JOURNAL and those whose articles have been abstracted in the Current Medical Literature Department. The * preceding the page reference indicates that the article appeared in full in THE JOURNAL.

A

Abadie, C., 1899
Abbott, A. C., 977
Abbott, D. P., *1414
Abbott, G. K., 746
Abderhalden, E., 1007, 1826
Abel, J. J., 336, 1298
Abelin, J., 428, 2092
Abell, I., 749, 1390
Abernethy, C., 1234
Abrahams, J. J., 1229
Abraham, R. B., 65
Acél, D., 2149
Achard, C., 503, 1006, 1231, 1898
Achelis, 1825
Acosta-Sison, H., 1894
Acton, H. W., 660, 2085
Acuña, M., 427, 754
Adair, F. E., *639, 821, 911
Adair, F. L., 575, 1397
Adams, D. K., 501, 825
Adams, S. F., 2084
Adamson, H. G., 659
Addis, T., 825
Adkins, W. N., 1811
Adler, A., 72
Adler, F. H., 1890
Adler, H., 168, 170
Adler, S., 421, 1994
Adlersberg, D., 168
Adolph, E. F., 997
Adrian, E. D., 661
Adrogué, E., 69, 1306
Adson, A. W., 1000
Agrifoglio, 1900
Ahigren, G., 1826
Ahlswede, E., 822
Aiello, G., 1305
Aikins, W. H. B., 240
Ainjouanine, T., 926, 1996
Albo, 1821
Albrecht, P., 666
Alderson, H. E., 746
Aldrich, J. A., *1425
Aldrich, M., *1194
Alessandrini, A., 827
Alessandrini, P., 166, 1483
Alexander, J. C., 62
Alexander, W. A., 825
Alford, L. B., 657
Algora y Nieto, M., 1232
Allan, F. N., 495
Allan, G. A., 750
Allan, P., 1151
Allemann, R., 667
Allen, D. S., 823
Allen, E. G., 1889
Allen, F. M., 1476, 1727, *1937
Allen, P. W., 242
Allen, R. S., 1889
Allende, J. M., 755
de Allende-Navarro, F., 662
Allerton, P., 579
D'Allonnes, R., 1153
Almkvist, J., 1660
Alonzo, J. M., 68
Alpers, B. J., 656
Altherthum, L., 232
Altounyan, E. H. R., 751
Alvarez, W. C., 1887
Alwens, W., 1901
Amabile, L., 1305
Amato, A., 68
Ambard, L., 1083, 1653, 1654, 1731
Amoss, H. L., 157, 1147, 1992
Andersen, L. T., 1891
Anderson, C., 2087
Anderson, C. C., 659
Anderson, H. C., 1992
Anderson, P., *1679
Anderson, T. L., 247
Anderson, W. S., 1390
Andler, R., 589
Ando, K., 253
de Andrade, G., 166, 928, 2090
Andrewes, C. H., 1400
Andrews, C. J., *1780
Andrews, E., 499
Andrews, Y. L., 1728
Andrus, P. M., 1814
Anglade, 1655
Angle, E. E., *628
Angstein, J., 65
Anrep, G. V., 661, 1301
Anspach, B. M., 239, 1631
Antelawa, N., 1659
Anthony, R., 163
Antonovsky, A., 1402
Aoyama, 2148
Apert, E., 341
Apperly, F. L., 1820
Arala, G., 1483
Araya, R., 755
Arboleda, A., 250
Arce, J., 929
Archibald, E., 1394
Archibald, R. G., 582
Architouv, 1736
Arguelles, M. V., 580
Arimas, R., 2148
Arlolng, F., 1230, 1401, 1653
Armand-Delille, P.-F., 752, 1898
Armand Ugón, A., 1085
Armbruster, 1235
Arnesen, A. J. A., 1828
Arnoldi, 1901
Arnovlyévitch, 1654
Arpási, A., 589
Arrillaga, F. C., 754, 755, 1307, 1824
Artusi, G., 828
Asada, K., 1740
Ascher, 665
Aschner, B., 429
Ash, J. E., 580
Ashby, J. S., 332
Ashe, H. P., 990
Asher, L., 343, 1088, 2092
Askgaard, Y., 508, 1904
Astraldi, A., 256, 1306
Atkin, E. E., 500
Attix, F. F., 237
Aubaret, 927
Aubertin, C., 163, 585
Aubertin, E., 1083
Aubin, 1737
Audain, G., 928
D'Aunoy, R., 1648
Auricchio, L., 663, 2089
Austin, J. H., 1891
Auvray, 1996
Avery, O. T., 1148
Aviles, M., 1656
Avoni, A., 504
Avramovici, A., 424
Axhausen, G., 343
Axmann, 1825
Aycock, W. L., 157
Ayer, J. B., 242, 1299
Ayers, S. H., 498, 1395
Azoulay, 826

B

Baagøe, K., 1236
Babcock, R. H., *193, 820
Babkin, B. P., 560
Bachlechner, K., 1157
Bachmann, F. M., 1078
Bacigalupo, J., 166
Backman, E. L., 590, 926
Backman, G., 1904
Bacon, C. S., 1564
Baehr, G., *1509
Baer, J. L., *526
Baer, R., 1234
Baer, R. W., 917
Baetjer, W. A., 1888
Bagg, H. J., 917, 1570
Baggio, G., 425
Bagley, C., Jr., 657
Bagliani, M., 341
Bahn, K., 73
Bail, O., 344
Bailey, H., 2085
Bailey, P., 496, 918, 1814
Baird, J. P., 1310
Baker, L. A., 1812
Balado, M., 929
Balan, N. P., 1656
Balderrey, F. C., 1144
Balduzzi, O., 1152
Baldwin, B. T., *1
Baldwin, H. S., 1908
Balfour, D. C., 237, 1393
Baliña, P. L., 929
Ball, J. M., 324
Ballenger, E. G., 62, *1023, 1811
Ballin, 345
Balsamoff, 1575
Balthazard, 661
Banciu, A., 926
Bancroft, F. W., 241, 1639
von Bandel, R., 1405
Banerjee, D. N., 1733
Bannerman, R. G., 1081
Bansi, H. W., 1090
Banzhaf, E. J., 580
Banzhaf, H. L., 892
Barach, J. H., *347
Barát, I., 1234
Barbaro Forleo, G., 425
Barbee, J. T., 1471
Barber, R. F., 1643
Barberi, S., 1656
Barborka, C. J., 1990
Barbosa, J., 504, 753, 1403, 1823
Barbour, H. G., 496
Barclay, W. S., 157
Barcroft, J., 660
Bard, L., 1004
de Barenne, J. G. D., 1233
Bargen, J. A., 1728
Bariétte, 1655
Barinetti, C., 425
Barkan, O., *190, 242
Barker, P. S., 1896
Barkus, O., 1392
Barnes, A. R., 1649
Barnes, N. P., 155, 1571
Barnett, C. E., 999
Barnett, E. J., 159
Barosh, F., 2000
Báron, 2149
Barr, C. C., 579
Barr, D. P., 1816
Barr, R. A., 236
Barrett, J. A., 164, 1304, 1655
Farret, H. P., *113
Barreto, A. L. B., 1476
Barringer, E. D., 580
Barringer, T. B., Jr., *516
Barron, M., *2010
Barros Lima, 1900
Barrow, J. V., 334
Barry, D. J., 1901
Barry, W. M., 1474
Bársony, T., 664, 1309, 1743, 1999
Bartels, B. A., 921
Barth, E., 252
Bartley, S. P., 1468
Bartos, E., 921
Bartrina, J. M., 342
Baruk, 1655
Basch, F., 1575
Bass, 662
Bass, C. C., *1503
Bass, M. H., 1473, 2078
Bastai, P., 830, 1308
Battle, W. H., 583
Batlles G. Bertrán de Lis, A., 1154
Baudet, R., 340
Bauer, E., 345
Bauer, J., 2149
Bauer, K. H., 1738
Bauer, V., 1225
Baughman, G., 1650
Bauguess, H., 1223
Bauman, L., 999
Baumann, M., 1157
Baumm, H., 429
Baur, H., 1689, 1999
Bayer, R., 667
Bayne-Jones, S., 157
Bay-Schmith, 1900
Bazán, F., 69
Bazán, J. E., 1573
Bazin, A. T., 2082
Bazy, P., 340
Beach, W. M., *790
Beall, K. H., 1893
Beams, A. J., 655
Becher, E., 1575, 1660, 1903
Bechterew, W., 662
Beck, A., 1657
Beck, C. S., 2077
Beck, W., 1234
Becker, L., 1575
Beckwith, T. D., 1223
Bedarida, N. V., 1738
Bedell, A. J., *363
Bedson, S. P., 500
Beer, E., 1145
Beerman, P., 655
Behrend, M., *875, 990
Belding, D. L., 1076, 1077, 1475
Belfield, W. T., *1237
Bell, J. R., 1727
Bell, W. B., *1002
Benard, R., 163
Benda, R., 752
Bender, L., 1392
Bendes, J. H., 63
Benedict, A. M., 1892
Benedict, F. G., 249
Benjamin, J. E., 426, *1861
Bennett, A. E., *957
Benon, R., 1231
Bensuade, R., 248, 661
Benthin, W., 1007
Bento de Lemas, 928
Bérard, L., 1822
Bercovitz, N., 1713, *2032
Berczeller, L., 830
von Berencsy, G., 1309
Berens, C., Jr., *1024
Beretervide, E. A., 251, 1155, 1307
Berger, E., 2091
Berger, H. C., 1818
Berger, J., 1997
Bergman, G. W., 497
Bergstrand, H., 430
Bergstrom, V. C. A., 2079
Berisso, O. A., 1657
Berkeley, C., 1652
Bernard, 826
Bernardbeig, J., 1822, 1996
Di Bernardo, A. L., 1900
Berner, O., 74, 1006
Bernhard, A., 1223
Bernhardt, H., 757, 1089, 1090
Bernheim, A. R., *291
Bernheim, E., 344, 757, 1740
Bernheim, M., 752
Bernstein, M., *1915
Bernton, H. S., *1434
Berro, R., 2089
Bertone, C., 249, 2000
Bertrand-Fontaine, 1400
Besnard, 1005
Besredka, A., 339
Best, C. H., 1889
Betchov, N., 1899
Bethke, R. M., 243
Béthoux, L., 424
Bettinotti, S. I., 2089
Bettman, R. B., *359, 823, 1473
Beumer, H., 1008, 1234
Bezançon, F., 826, 1005, 1153, 1997
Biancani, E., 1231
Bianchini, A., 249
Biasotti, A., 754, 1083
Biberfeld, H., 1740
Bickel, A., 251
Bickel, G., 339, 425, 1084, 1056
Bier, A., 757, 1903
Bierich, R., 930
Bierring, W. L., 1071
Bierry, H., 164, 826, 1303, 1996
Biesalski, K., 167
Bieter, R. N., 1889
Bigalow, R. M., 157
Bigger, I. A., 63
Bigland, A. D., 337
Bigwood, E. J., 243, 926, 1481, 1988
Bilancioni, G., 586
Bilger, F., 67
Billa, 1401
Billings, F. T., 156
Bing, R. L., 346
Bing, R., 662, 1084
Bingel, A., 1574
Binger, C. A. L., 1808, 1992, 2077
Binswanger, O., 1656
Bircher, E., 165
Birch-Hirschfeld, 1658
Birkholz, 2150
Birt, E., 157
Bisgaard, A., 508
Bishop, G. H., 578
Bissinger, E., 428
Bith, 661
Bittman, F. R., 1648
Bittmann, O., 1010
Bittorf, A., 1739
Black, A., 243
Blacklock, B., 1994
Blacklock, J. W. S., 501, 825
Blackmar, R. W., 1984
Blaine, E. S., 1391
Blake, F. G., *712, 1724, 1988
Bland, P. B., 1475
Blatherwick, N. R., 418, 496
Blatt, P., 1157
Blaxland, A. J., 2085
Blechmann, 1004
Blegvad, O., 430, 1904
Bleuler, E., 663
Bliedung, C., 1233
Bloch, B., 1089
Bloch, C. E., 917
Bloch, E., 931, 1740
Bloch, M., 2088
Bloch, S., 1898
Block, E. B., 1812
Block, F. B., 236
Block, W. H., 1382
Bloedorn, W. A., *622
Bloise, N. L., 342, 753
Blondel, R., 248
Bloodgood, J. C., 1145, 1223, 1299, 1643, 1882
Bloom, D., 2087
Bloom, W., *547
Bloomfield, A. L., 157, 334, 1730
Bloomfield, A. O., 1888
Bloor, W. R., 1891
Blouw, H. C. V., 1406
Blue, J. B., 1389
Bluemel, C. S., *209, 997
Blum, 423
Blum, P., 1004
Blum, R., 344
Blumenstock, J., 997
Blumenthal, G., 2148
Blumgart, H. L., 1729, 1896
Blunt, K., 243, 1227
Boas, E. P., 335, *1506, 1729, 1896
Boas, H., 832, 1236
Boas, I., 252
Bocek, 1010
Bock, A. V., 1816
Bock, J. C., 1225
Bockus, H. L., *351
Bodansky, M., 578
Bode, F., 70
Bodenheimer, W., 2091
Boeckel, A., 67
Boelke, P. W. R., 581
Boez, 502
Bogroff, 1824
Böhm, 1156
Böhme, W., 1233
Bohne, 506
Bohnen, P., 1575
Bohnenkamp, H., 665
Boisseau, H., 247
Boissel, 662
Bok, S. T., 668
v. Bókay, J., 1404, 1486
Boland, F. K., 236
Boles, R. S., *303, *2112
Bollack, J., 927
Bolten, H., 254
Bolton, C., 924
Bondi, S., 1999
Bonem, P., 1157
Bonnaire, 1821
Bonnet, 1654
Bonney, V., 246
Bonnier, G., 1828
Bonnin, H., 1736, 1822
Bonorino Udaondo, C., 754, 1573
Boohler, L. E., *200, 1892
Boone, F. H., 575
Boone, W. B., 160
Boorstein, S. W., *862
Boothby, W. M., 919, 1990
Boots, R. H., 61, *1028, 1988
Boquist, S. S., 93
Borak, J., 1742
Borchard, E., 587
Borchardt, L., 588
Bordet, J., 1307
Bordier, H., 340, 1402
Borel, 1822
Borger, E., 1235
Borges Pereira, C., 587
Borgherini - Scarabellin, A., Jr., 1006, 2089
Bornstein, A., 1823, 1826
Borrel, A., 502
Bosco, G., 166
Bose, J. P., 1572
Boss, W., 1405

Boston, L. N., 244
Bostrom, E. F., 496
Böttner, A., 2091
Boulet, 1153
Boulin, 661
Bourgeois, 1737
Bourguignon, G., 584
Bourne, G., 825
Bouttier, H., 663
Boven, W., 1084
Bovin, E., 590
Bowcock, H. M., ✱702
Bowden, D. T., 1730
Bowditch, H. I., ✱1422
Bowdoin, J. P., 1812
Bower, J. D., 240
Bowers, C. H., ✱1325
Bowing, H. H., 1228
Bowman, A. K., 338
Boycott, A. E., 1734 ✱
Boyd, D. R., 1646
Boyd, M. F., 918
Boyd, M. L., ✱792, 1300
Boyer, 1823
Bozzolo, G., 1305
Braasch, W. F., ✱688, 1649
Bradley, R. L., 1144
Brady, L., 334
Braeunig, K., 1825
Brahmachari, U. N., 161, 660, 1733
Braine, J., 164
Braithwaite, J. V. C., 1301
Brams, J., 62, ✱1166
Bramwell, B., 1228
Bramwell, J. C., 2086
Brancati, R., 2089
Branch, A., 2057
Branch, C. F., ✱1260
Brandão, A., 587
Brandenburg, K., 1826
Brandt, P., 506
Brandt, W., 343
Bratusch-Marrain, A., 345, 1404
Braun, H., 588
Braun, M., 423
Braunstein, A., 1902
Bravo, J., 822, 1998
Brawner, A. F., 1812
Brawner, J. N., 1812
Brea, A. M., 505
Breger, 830
Breinl, F., 344, 497, 755
Breitet, 248, 661
Brem, W. V., 332
Brereton, T. C., 156
Breuer, F., 1742
Breukink, H., 1236
Brewster, A. H., ✱1115
Briggs, A. P., 1816
Briggs, H. W., 972
Briggs, L. H., 495
Brill, N. E., 417
Bringmann, K., 2148
Brinkmann, 169, 1089, 1742
Bristol, L. D., 495
Bristow, W. R., 920
Broadbent, W., 583
Brock, J. H. K., 1735
Brocq, L., 826
Brocq-Rousseau, 826
Brodier, L., 1153, 1482
Brodin, P., 1005, 1996
Brodnax, J. W., ✱440
Broekmeyer, J., 2092
Broman, J. R., 576
Bronfenbrenner, J. J., 1647
Bronfin, I. D., 332
Brooks, B., ✱1016, 2146
Brooks, H., 1732
Bröse, P., 2150
Broster, L. R., 63
Brouet, 662
Brouha, L., 1481
Broun, G. O., ✱963, 2078
Brousseau, A., 1573
Brouwer, J., 663
Brouwer, E., 71
Brow, G. R., 1992, 2077
Brown, A., 917, 1473
Brown, A. J., 238
Brown, A. L., 336
Brown, C. H., 819
Brown, G., 1003
Brown, G. E., 1077
Brown, van A., 1818
Brown, H., ✱88, 822, ✱1911
Brown, H. H., 1995
Brown, P. K., 1144
Brown, R., 1396
Brown, W. E., ✱1039
Brown, W. H., ✱5, 1992
Brown, W. L., 245
Browne, G. J., 924
Bruce, J. W., 420
Brugsch, T., 665, 1825, 2146
Brulé, 423, 1305
Brunt, E., 1305
Brüning, F., 1233, 1901
Brunner, H. C., 827
Brünner, K., 1742
Bruns, O., 505
Brunschweiller, H., 1084
Brusa, P., 1154, 1998
Bruusgaard, E., 430
Bryan, W. A., 1470
Bryant, B. L., 976
Bryant, J., 1727
Brydson, J. M., 925
Buchanan, G., 1150
Buchanan, J. A., 2146
Büchner, S., 428
Buckman, T. E., ✱1489
Buckmaster, G. A., 421
Buckstein, J., 146, 1139
Budde, M., 2149
Bugg, C. R., 1395
Bulatao, E., 997
Bull, P., 1310
Bulmer, E., 1301
Bumke, O., 1308
Bumm, E., 345
Bunker, C. W. O., 750
Bunten, J. C., ✱1443
Burch, L. E., 1469
Burckhardt, H., 427
Burckhardt-Socin, O., 505
Burden, V. G., 1645
Burger, G. C. E., 1233
Burger, H., 668
Burger, K., 1325
Burgess, N., 1003
Burghi, S. E., 68, 342
Burgkhardt, F., 1660
Burke, E. T., 163
Burke, J., ✱790
Burke, V., 1078
Burky, E. L., 1395
Burnand, R., 423, 1482, 2148
Burnet, E., 2057
Burnet, F. M., 1480
Burns, J. E., ✱1587
Burrow, J. L. F., 582
Burrows, H., 422
Burrows, M. T., 323
Bursey, E. H., 1228
Burstein, J., 921
Burton, E. D., ✱844
Busacca, A., 830, 1308
Buschke, A., 343, 1485
Buschmann, T. W., 498
Businco, A., 2089
Bussa Lay, E., 827
Bussard, C., 1653
Bustos, F., 251
Butka, H. E., ✱875
Butler, C., 250
Butler, E. F., 891
Buttenwieser, S., 2091
Buzzard, E. F., 338
Byford, W. H., 1817

C

Cabassi, E., 504
Cadarlu, 1401
Cadbury, W. W., 64, 918
Cady, L. D., 1076
Caillon, J., 2086
Cain, A., 165, 248, 661
Caius, J. F., 161, 162
Cajori, F. A., 1988
Calhoun, T. J., 1393
Callenberg, 71
Calmette, A., 67, 1653
Calot, 1230
Calzavara, D. 1310
Camauer, A. F., 504, 929
Cambessèdès, H., 424
Cameron, A. L., ✱1187, ✱1410
Cameron, A. T., 156
Camp, H. F., 1078
Camp, H. M., 738
Camp, J. D., 1000
Campanacci, D., 1309
Campbell, D., 924
Campbell, E. A., 658
Campbell, L. L., 919
Campbell, W. C., 922, 1471
Campbell, W. R., 1990
Camus, J., 164
Canavan, M. M., ✱716
Cancik, J., 1660
Canitano, S., 1997
Cannan, R. K., 661
Cannon, A. B., 821
Cannon, H. C., 578
Cannon, P. R., 1148
Cannon, W. B., 1725
Cantile, N., 1151
Capen, S. P., 1072
de Capite, A., 249, 1006, 1656
Capon, N. B., 750, 1895
Capps, J. A., 1642
Caputi, G. B., 165
Caraven, J., 1654
Carbo-Noboa, J. M., 1998
Cardoso, E., 166
Cardoso Fonte, 1900
Carey, E., 578
Caridroit, F., 1653, 1898, 1904, 2000
Carlier, 423
Carlini, P., 165
Carlson, A. J., 997, 1296
Carman, R. D., 1000, 1649
Carmichael, C. J., 1469
Carniol, A., 1481
Carnot, P., 1402, 1653, 1654
Caronia, G., 164, 425
Carp, L., 1645
Carpenter, E. R., 1650
Carr, W. L., 819
Carra, J., 166
Carrel, A., 61, ✱255, 1230
Carrington, G. L., 2079
Carroll, W. E., 1146
Carson, W. J., 1477
Carter, B. N., 745
Carter, E. P., 334, 2077
Carter, J. E., 754, 1573
Casaubón, A., 427, 1738
Case, J. T., ✱208, 240, ✱2071
Caserto, A., 2089
Casey, G. U., 1227
Caspari, W., 1309
Casper, L., 587
Cassaët, E., 1822
Castagna, F., 1232
Castana, Y., 341
Castaño, C. A., 427
Castellani, A., 1480
Castellano, T., 1656
Castex, M. R., 504, 663, 928
Cathala, V., 1231
Catlin, J. J., ✱107, ✱2030
Catouillard, G., 2087
Catteruccia, C., 586
Catzeflis, A., 1303
Cauthorn, F., 1883
Cavazzutti, G. B., 754
Cawston, F. G., 1734
Caylor, H. E., ✱1337
Ceballos, 166
Cecchini, A., 506
Cecil, H. L., 1228
Cecil, R. L., 1640, 1988
Cederberg, O. E., 1310
Ceillier, A., 164
Celasco, J. L., 69
Ceresole, G., 1005
Ceresoli, A., 1900
Cervera, J., 929
Cestan, 1736
Chabanier, H., 248, 1005, 1899
Chabrol, 1821
Chaffin, W. W., 658
Chagas, C., 1822
Chambers, E. R., 245, 1995
Chambers, H., 1081
Champy, C., 827, 926
Chandler, G. F., 1143
Chaney, M. S., 1889
Chaney, R. H., 1810
Chaney, W. C., ✱2013
Chaoul, 1825
Chapman, O. D., 1890
Chapman, R. McC., 1075
Charlton, P. H., 1647
Chatellier, H., 927
Chauffard, A., 340, 1996
Chaussebianche, 1304
Chavigny, M., 927
Cheatle, G. L., 64, 1819
Cheever, D., 1739
Cheinisse, L., 164, 752, 1231
Chen, C. S., 253
Chesky, V. E., 658
Chesney, A. M., 62, 1648
Chevallereau, A., 927
Chevrier, L., 1997
Chevrotier, 1653
Chiari, H., 1743
Chirus, J., 752
Chirié, J. L., 1899
Choisser, R. M., 1894
Chopra, R. N., 64
Christensen, B. E., 1389
Christensen, L., 508
Christensen, O., 170
Christian, H. A., 1726, ✱2011
Christianson, J., 1083
Christianson, H. W., 1649
Christina, V., 1076
Christoffel, H., 2089
Christopher, F., 1300, ✱1661
Christopherson, J. B., 581, 1735
Chu, J. S., ✱2032
Ch'un, C., 1896
Churchill, E. D., 1300
Chute, A. L., 1731
Cieza Rodriguez, L. F., 754
Cifuentes, P., 1998
Ciminata, A., 1405
Ciofi, E., 1823
Ciotola, A., 341
Cirillo, G., 1230
Citron, K., 664, 829
Clairmont, P., 663, 1153
Clark, G. A., 1301
Clark, J. G., 236, 1631
Clark, J. H., 240
Clark, L. P., ✱770
Clark, O., 504
Clark, T. L., 1399
Clarke, H. C., 1477
Clarke, T. W., 1227
Clarkson, S., 417
Claude, H., 164, 927, 1573, 1655, 1822
Clavelin, C., 503
Clawson, B. J., 1076
Clayton, M. M., 1731
Clearp, E. W., 1891
Clemens, J. R., 1065, 1217
Clerf, L. H., ✱630
Clough, H. D., 1889
Coates, L., 1734
Cobb, S., 582, 1296
Cobet, R., 664
Coburn, R. C., ✱1748
Cocea, A. P., 243
Cochez, P., 424
Cochrane, W. J., 1646
Cockrell, J. R., 1991
Codman, E. A., 974, 1882
Coffey, R. C., 235
Coglievina, B., 1903
Cohen, H., 824, 1300, 2087
Cohen, P., 1473
Cohn, A. E., 998, 1721
Cohn, I., 236, 2146
Cohn, L. C., 1145
Cokkinis, A. J., 1229
Cole, H. N., ✱199, 1076, 1890, ✱1909
Cole, W. C. C., 498
Cole, W. H., ✱613, ✱1777
Colebrook, L., 422
Coleman, C., 234
Coleman, T. C., 1812
Coley, B. L., ✱2031
Coley, S. W., 1471
Coley, W. B., 1992, 1645
Collazo, J. A., 71, 251, 1088
Collier, F. A., ✱1745
Collett, A., 1223
Collier, J., 63, 1895
Colmers, F., 1157
Colombies, 1996
Colston, J. A. C., 157
Colwell, N. P., 150, ✱838
Combiesco, D., 1653
Comby, J., 1004
Cometto, C. S., 754
Compton, A., 1151
Compeyron, L., 580
Condorelli, L., 1153, 1305
Connell, J. W., 575
Connell, K., 1992
Conner, H. M., 1991
Connor, W. H., 1894
Conroy, M. J., 241
Contamin, N., 827
Conway, E. J., 661
Cook, J. A. L., 925
Cook, R. J., 920
Cookson, H. A., 1228, 1897
Cooper, E. F., 331, 997
Cooper, H. S. F., 1223
Cooper, S., 661
Cope, Z., 824
Copher, G. H., ✱781, 1571, ✱1777
de Coquet, F., 1904
Corcoran, W. J., ✱626
Cordes, E., 1739
Cordes, F. C., ✱519
Cori, C. F., 656, 1477
Cori, G. T., 656, 1992
Cormack, J. G., 1512
Cornil, L., 1006
Cornwall, J. W., 1652
Cornwall, L. H., 240
Corper, H. J., 61, 333, 1144
Corpus, P., ✱1192
Cortes Llado, M., 1306
Costa, I. P., 1824
Costa, S., 1822
da Costa Cruz, J., 1463, 1822
Costain, W. A., 1001
Cotte, G., 662
Cottenot, P., 826
Cottle, G. F., 1894
Cotton, T. F., 1150
Coughlin, W. T., 1818
Coulaud, F., 584, 826
de Coulon, 502
Courmont, P., 662
Courrier, R., 1654
Courtney, A. M., 331
Courtney, J. W., 497
Coury, A., 1230
Couvert, C., 1154
Covey, G. W., 1393
Cowdry, E. V., ✱545
Cowie, D. M., 336
Cox, H. H., ✱2021
Cozzolino, O., 2089
Cragg, F. W., 660
Craig, W. McK., 1478
Crainiclanu, A., 1231
Cramer, O., 1404
Cramer, W., 160, 1480
Crance, A. M., ✱1930
Crawford, A. M., 501
Crawford, A. S., 1000
Crawford, E., 1082
Crile, G. W., 1224, 1225, 2079
Cristalli, G., 1656
Critchley, M., 1150
Crofton, W. M., 1301
Crooks, M., 1298
Crooks, T. T., ✱109, ✱204
Cross, D. G. T. K., 659
Crossen, R., 2079
Crothers, B., 499
Crouter, C. Y., 1988
Crouzon, 249
Crowdy, C. T., 2079
Crowe, S. J., 334, 917
Crowe, T. J., 973
Cruciani, J. A., 1154
Cruickshank, J. A., 660
Cruickshank, J. N., 246, 924, 1082
Crummer, Le⁰., ✱1420
Cruz, A. O., 1086
Cullen, T. S., 2146
Cummings, E. H. T., 421
Cummins, S. L., 583, 1001, 1733
Cunningham, H. K., 1472
Cunningham, J., 660
Cunningham, R. S., 1730
Currier, G. S., 925
Curschmann, H., 665
Curtis, A. H., 114
Curtis, R. D., 239
Curtius, F., 1086
Cushing, H., ✱841
Cutler, E. C., 1223, ✱1763, 2077
Cutler, G. D., 499, 2081
Cutter, I. S., 1070
Czerny, A., 1404
Czickel, H., 589
Czubalski, F., 1152
Czyhlarz, E., 1007

D

Dabney, V., ✱956
Da Costa, A. F. W., 581
Daels, F., 1005
DaFano, C., 824
Dahlberg, G., 1904
Daland, E. M., 577
Daland, J., 746
Dalla Valle, A., 1006, 2079
Daly, I. DeB., 1002
Daly, P. A., ✱1439
Damade, R., 67
Dambrin, C., 1822
Dameshek, W., 1297
Damon, S. R., 1734
Dana, H. W., 820
Danielopolu, D., 421, 1481
Dansey, St. J. W., 1003
Danzi, M., ✱876
Darbois, 164
Das Gupta, B. M., 245, 751, 1651
Dattner, B., 830
Dausset, 1997
Dautrebande, L., 1303
Davenport, C. B., 2080
Davenport, G. L., ✱1840
David, V. C., ✱21
Davidson, L. T., 331
Davidson, M. B., 1809
Davidson, P. B., ✱714
Davis, A. B., 1728
Davis, C. H., 240, ✱1607
Davis, G. G., 333, 1079, 1890
Davis, E., 999
Davis, J. E., 821
Davis, J. S., 822
Davis, M., 1476
Davis, R. B., 1471
Davis, R. C., 60
Davis, W. B., 1631
Davis, W. D., 1393
Davison, H. M., 1912
Dazzi, H., 1900
De, M. N., 1151
Dean, H. R., 824
Dean, M., 147
Deane, H. C. C., 422
Death, W. A., 746
Deaver, J. B., ✱2115
Debré, R., 927, 1303
DeBuys, L. R., 917, 2078
Dechaume, J., 1153
Decker, H. R., 746
DeCourcy, T. L., 659
Decrop, 339
Deelman, H. T., 74
Degkwitz, 1904
Deist, H., 247, 343, 2091
Delamare, G., 1736
Delater, 502
DeLee, J. B., 1564
Deleszenne, C., 163
Delherm, L., 1231
Delore, X., 1083, 1304
Deizell, W. R., ✱270
Demaria, E., 754, 1823
Denis, W., 1728
Dennig, H., 1902
Denoyelle, 1303

Denzer, B. S., *1243, 1473, 2078
Depisch, 1743
Derick, C. L., *1778
DeSanctis, W. T., 1471
Desgrez, A., 164, 1996
Dessaint, 163
Dessauer, F., 1741
Destéfano, F., 167, 1484
DeTarnowsky, G., *1505
Detweiler, H. K., 1721
Deutsch, H., 1224
Devola, A., 1655
DeWitt, L. M., 333, 1392
Dexeus Font, S., 1306
Diamantis, 827
Diamond, J. S., 1813
Dible, J. H., 1734
Dick, G. F., *265, *301, *544, *1246, 1724, 2084
Dick, G. H., *265, *301, *544, *1246, 1724
Dick, W., 1085
Dickens, F., 1082
Dickson, F. D., 1816
Dieckmann, A., 1739
Dieckmann, W. J., 819
Diehl, H. S., *951
Dieterich, H., 1740
Dietl, C., 1405
Dietrich, H. A., 931
Dieuaide, F. R., 334, 2077
Digby, K. H., 65
Diller, T., 1153
Dillon, J. R., *287
Dimick, A., 243
Dimitri, V., 1656
Dind, 165
Dingwall, 163, 502
Dixon, C. F., *1498
Dixon, W. C., 1472
Dixson, T. S., 1003
Djérnil, 1736
Djérup, 1576
Dmitrenko, L. F., 1889
Doane, J. C., *1105
Dobrovolskaia-Zavadskaia, N., 1482
Dochez, A. R., *542, 1641
Dock, W., 1991
Dodds, E. C., 500, 661, 1652
Dodson, C. M., 975
Doerr, R., 249, 503, 586
Dognon, A., 1653
Doijer, J., 2150
Dolbey, R. V., 1229, 1302, 1400
Dold, H., 1740, 1741
Dolfus, 425
Dolshansky, 1658
Dominguez, N. M., 1076
Donald, J. R., 998
Donald, R., 1660
Donald, W. G., 1801
Donath, F., 1659
Donath, J., 2092
Donath, W. F., 1828
Donnally, B. H., *1318, 1473
Donzelot, E., 1737
Doods, E. C., 1082
Dooneief, G., 1729
Doria, R., 827
Dorne, M., 1298
Dornedden, H., 2148
Dotson, W. S., 1389
Dott, N. M., 63
Douglas, B., *381
Douglas, J., *1607
Douglass, B. A., 1471
Doull, J. A., 155
Dourmashkin, R. L., *2025
Dow, J. E., *1678
Downes, W. A., *1315
Downs, A. W., 418
Doyon, M., 936
Dozier, C. C., 498
Draganescu, 423
Dragstedt, L. R., 331, 2081
Drake, W. F., 1818
Draper, G., *431, 1989
Dresel, K., 505, 1088
Drew, A. H., 160
Drew, K., 924
Drinker, C. K., 2077
Drucker, P., 254
Drury, D. R., 999, 1396
Druskin, S. J., *370
Duarte Salcedo, 753
Dubois, C., 503
Du Bois, E. F., 1224
Dubois, F. G. J., 1158
Dubois, M., 506
Dubois, R., 1303
DuBois, R. O., 239
Duchenau, L., 1083
Duchon, M., 248
Dudgeon, L. S., 2085
Dufour, H., 248
Dufourt, A., 1401, 1653
Duhamel, 1898
Duhem, P., 1304
Duhot, R., 1823
Dührssen, A., 1902
Duke, W. W., 59, *939
Dumpert, V., 1903
Dumphy, J. J., 1297
Duncan, A. G., 1896
Dunhill, T. P., 659
Dunlap, C. R., 1075
Dunlop, E. M., 825
Dunn, H. L., *431, 1989
Dunn, N., 1816
Dünner, L., 1485
Dunning, M., 1078
Dupouy, R., 1083
Durand, H., 662, 1898
Durand, P., 584
Durham, O. C., *939
Duschl, L., 73
Dustin, C. C., *874
Duval, C. W., 922
Duval, P., 1303, 1821
Durin, 661
Dye, M., 1989, *2111
Dyke, S. C., 824

E

Eagleton, W. P., *2100
Ebaugh, F. G., 1223
Ebbecke, U., 930
Ebeling, A. H., 61, 1402
Eblen, J. G., 1471
Echeverri Marulanda, A., 250
Eckert, M., 1098, 1487
Eckstein, A., 588, 1404, 1659
Eckstein, G., 1731
Eddie, B. U., 1225
Eddy, N. B., 918
Eden, R., 1825
Ederer, 342
Edgehill, W. M., 823
Edholm, G., 932
Edmunds, C. W., 1065, 1809
Edsall, D. L., 893
Edwards, A. C., 1001
Edwards, D. J., 575
Edwards, F. G., *1260
Edwards, J. G., 66
Eerland, L. D. 758
Effront, J., 926
Egan, E., 1999
Egerer-Seham, G., 331
Eggers, C., *1415
Ehlers, 170
Ehrmann, R., 930
Ehrström, R., 1902
Eichel, O. R., 1567
Eichelter, G., 1743
Eick, E., 1309
Eick, K., 1485
Eidenow, A., 1735
Eijkman, C., 1896
Eikenbary, C. F., *78
Einstein, O., 931
Eisendrath, D. N., *717
Eisler, F., 1903
Eider, O. F., 62, *1023, 1811
Elek, L., 830
Eliason, E. L., *1934
Eilermann, V., 1236, 1488
Elliott, J. A., 1145
Elman, R., 1147
Eloesser, L., 1144
Elsberg, C. A., 1297
Elsner, H., 1824
Elsner, J., 1406
Elwes, F. F., 2085
Elwyn, H., *381
Elze, C., 1826
Embden, G., 830
Emerson, H., 1887
Emerson, P. W., 227
Emge, L. A., 244
Emile-Weil, P., 164
d'Empaire, A., 1484
Encisco, E., 1484
Engel, C., 2090
Engelbach, W., 1078
Engelen, 1738
Enright, J. R., *1104, *1504
Epplen, F. J., 1290
Epstein, A. A., 1990
Epstein, B., 1307
Epstein, J., 1991, 1997
Erb, I. H., 575
Erdmann, R., 345
Escuder Nuñez, P., 1373
Escudero, P., 734
Eskuchen, K., 71
Espejo, L. D., 68
Esposito, A., 1006
Estapé, J. M., 1403
Estes, W. L., 1300
Esty, J. R., 1895
Etienne, G., 423, 1656
Eubanas, F., 1080
Eusterman, G. B., 1474
Eustis, A., 749
Evans, F. A., 1147
Evans, G., 825
Evans, J. S., 823
Evans, W. A., 828
Everett, H. S., 157
Evrard, 1303
Ewald, E., 1144
Ewald, G., 1486
Exchaquet, L., 503
Exton, W. G., *591, *1838
Ezekiel, G. A., 658

F

Faber, A., 1158, 1904
Faber, H. K., 239, *413
Faber, K., 1488
Fabricus-Møller, J., 1904
Fabry, J., 666
Fabry, P. 926
Faerber, 252
Fahmy, I., 1229
Fähracus, R., 932
Fahrenkamp, K., 1007
Fahrni, G. S., 1147
Fairley, K. D., 1400
Fajardo da Silveira, F., 928
Falconer, E. H., 1813
Fales, W. T., 155
Falk, M. A., *2097
Fallon, M. F., 1394
Falta, W., 1089, 1743
Fancher, H. L., 1469
Fanconi, G., 1404, 2088
Fanelli, 165
Fansler, W. A., 1000
Farani, A., 426, 928, 1998
Farmer, W. C., 923
Farr, R. E., 1143, *1199, *1774
Farrell, J. T., Jr., 820
Fassl, E., 73
Faust, E. C., 283, 751
Favre, M., 827
Faxon, N. W., 1073
Fay, T., *766
Fecht, 829
Feinblatt, H. M., 1076
Feissly, R. 423, 662, 2092
von Fekete, A., 588
Felklová, L., 831
Felsen, J., 1076, *1415
Felsenreich, G., 664
Felty, A. R., 157, 334, 747, *1430, 1730
Fenel, E. A., 499
Fenger, F., 1225
Fenn, G. K., 921
Fenn, W. O., 661
Fennel, E. A., *538
Ferguson, D., 749
Ferguson, J. H., 246
Fernández, A. A., 69
Fernando, A. S., 159, 1149
Fernish, C. A., 155
Ferraro, 828
Ferreri, G., 828
Feuillié, E., 164, 926
Feyertag, H., 588
Field, H., Jr., 1816
Fieschi, D., 1738
Fiessinger, C., 1401
Fiessinger, N., 1005, 1821, 1898
Figueira de Mello, P., 1901
Figueras, J. A., 1999
Filip, L., 2094
Fineman, S., 1991
Finesilver, B., *1608, 2069
Fink, K., 588
Finkbeiner, 1658
Finlayson, A. D., 922
Finley, F. G., 2086
Finnerud, C. W., *775
Finsterer, H., 168, 346
Fiori, P., 504
Fiorito, G., 1656
Firor, W. M., 1395, 1730
Fischel, E., *10
Fischer, L., 335, 1488, 2149
Fischer, A. W., 342
Fischer, E., 345
Fischer, H., 1741
Fischer, P., 1902
Fischer, R., 163
Fischer, W., 829
Fischler, F., 344, 1487
Fishberg, A. M., *463, 2077
Fisher, D., *699
Fisher, N. F., 331, 332, 997, 998
Fisk, T. L., 568
Fismer, G., 661
Fitchet, S. M., *1120
Fitz, K., *435, 655, 1989
Fitzgibbon, G., 1001, 1081
Fitz-Hugh, T., Jr., 495
Flamini, M., 249
Flatau, E., 1230
Fleck, R. F., 820
Fleischner, F., 1307
Fleischer, R., 667
Fleming, H. G., 1228
Fleming, W. D., 580
Flexner, A., *833
Flexner, S., 1147, 1992
Flipse, M. J., 745
Flood, R. G., *1595
Flörcken, H., 427
Floyd, R., 1476
Floyd, W. O., 1470
Fløysirup, G., 932
Flu, P. C., 74
Flury, F., 252
Flynn, C. W., 1650
Fogelberg, H., 1310
Foix, C., 249, 1653
Foley, F. E. B., 1894
Folkmar, 508
Folkoff, C., 1395
Foltz, P., 2089
Foncin, R., 1004
Fonio, A., 165
Fontaine, R., 67
Fontanel, 1083
Fonteyne, P., 584
Foot, N. C., 745
Forbes, H. S., 1296
Ford, F. R., *1046, 1395, 1730
Fordyce, A. D., 1895
Fordyce, J. A., 821, 1075, 1394, 1813
Forget-Urion, 586
Forni, G., 504
Forsyth, D., 1995
Forsyth, J. M., 1994
Fort, A. G., 1812
Foss, H. L., 1992
Fossataro, E., 753
Fossier, A. E., *2016
Foster, H. E., 1991
Foster, N. B., 59
Fothergill, W. E., 1479
Fourneau, E., 1302, 1736
Fowler, W. F., 241
Fox, H., 1076
Fox, H. H., *467
Fraenkel, M., 829
Fraga, A., 929
Fragomele, A., 425
Framm, 755
Franchini, G., 67
Franchini, Y., 166
Franck, 1006
Frank, E., 1740
Frank, M., 1637
Frank, R. T., *619
Franke, F., 830, 1009
Franke, M., 1152
Franke, U., 505
Frankenstein, C., 1008
Franklin, E. A., 334
Franklin, W. S., *519
Franz, L., 1574
Franz, T., 169
Fraser, A. R., 241
Fraser, D. T., *1114
Fraser, J., 575, 923
Fraser, J. S., 925
Frassi, L., 341
Frazer, E. B., 636
Frazier, C. H., *302, 822, 1145
Fredericq, M., 1230
Free, G. B. M., 333
Freed, H., 333, 1145
Freeman, W., 1145, 1153
Freeman, W. T., 1811
Fremont-Smith, F., 1296
de Frenelle, D., 2087
Freuchen, L., 1904
Freudenberg, E., 71, 252
Freund, E., 428
Freund, R., 665, 2091
Frey, E. K., 1009, 2093
v. Frey, M., 1405
Frick, A., *595
Fricke, R. E., 1300
Fried, A., 2092
Fried, B. M., 1814
Fried, E., 253
Fried, H., 748
Friedberger, E., 506
Friedemann, U., 507, 1307
Friedenwald, J., 1143, 1571
Friedjung, J. K., 755, 1008
Friedländer, A., 1904
Friedlaender, B., 1143
Friedlaender, W., 252
Friedman, J. C., *1248
Friedrich, H., 169, 170, 2091
Friedrich, L., 1745
Friesen, J. F., *1693
Frik, K., 1090
Frissell, L. F., 1077
Fritz, 588
Froelich, G., 67
Froemsdorff, C., 664
Fröhlich, R., 505
Froment, J., 164, 1153, 1402
Frommel, E., 425, 1084, 1656
Frontali, G., 250, 1306
Fronticelli, E., 1483
Fröschels, E., 756, 1088
Frossard, H. J., 1481
Frouin, 1821
Frühauf, J., 1010
Fuerst, 1008
Fujimori, S., 2092
Fukutaki, K., 2094
Fuller, E. B., 1897
Fullerton, A., 1001
Fulton, W. B., 997
Fumery, 1997
Funk, E. H., 1809
Funké, J., 740
Funknouser, W. L., 1811
Fusco, G., 827

G

Gabbe, E., 1741
Gabriel, G., 1484
Gadelius, B., 74
Gaehlinger, 1654
Gager, L., 1729
Gaián, E., 1085
Galant, J. S., 1657
Galdi, F., 250
Galland, W. I., *30 *1847
Galli, G., 1483
Galli, P., 68, 165
Gallie, W. E., 324, 917
Gallino, F. A., 1484
Gallo, C., 2089
Gambillard, M., 1152
Gamble, C. J., *387
Gans, O., 1308
Gänsslen, M., 588, 1089, 1156
Ganter, G., 345, 831, 1156, 1741, 1903
Garcia Faure, 755
Garcia, J., 1230
Gareiso, A., 1738
Garland, J., 331
Garofeano, M., 1154
Garrahan, J. P., 69, 250, 426, 427, 2089
Garrod, A., 825
Gate, J., 1401
Gauchat, H. W., 1296
Gaujoux, A., 662
Gauthier, A., 752, 1996
Gautier, C., 1083
Gautier, M. A., 1827
Gautrelet, 424
Gay, L. N., 334
Gayet, G., 1482
v. Gaza, W., 2092
de Gendrove, A., 1822
Geelmuyden, H. C., 1828
Gehse, U., 1087
Geiling, E. M. K., 336, 1298
Geist, E. S., 928, *960
Geist, F. E., 1816
Geist, S. H., 576, 2079
Gejrot, W., 589
Gekler, W. A., *457
Geller, F. C., 1740
Gemmell, A. A., 246
Genée, R. W., 1089
Génévrier, J., 662
Gennes, 1997
George, A. W., 1649
Georgeac, 164
Georgi, F., 428
Gerbasi, M., 568
Gerdes, 1233
Gerhartz, H., 1088
Gerlach, F., 1234
Gessner, H. B., 1393
Gessner, W., 1235
Gey, G. O., 157, *1699
Geyelin, H. R., 1988
Ghon, A., 1743
Giampaolo, 165
Giannuli, F., 663
Gibbon, J. H., 746
Gibbs, C. E., 918
Gibson, G., 825
Gibson, C. B., 1146
Gibson, C. L., 241
Gibson, H. J. C., 422
Gibson, J. G., *1918
Gibson, R. B., *468
Gibson, T. E., 576, 822, 998, 2080
Gifford, M. F., *1673
Gigon, A., 1089
Gilbert, A., 752, 1230
Gilbert, O. M., 820
Gilbert, R., 921
Gilbert, W., 2093
Gilchrist, D. B., *1287
Gilhespy, F. B., 1820
Gill, C. A., 162
Gilm, H. A., 1741
Ginsberg, G., *1517
Ginsberg, M., 2081
Gioja, E., 341
Giordano, S. S., 1577
Giordano, B., 1154
Giraldi, S., 587
Giraud, A., 1737
Giraud, P., 584, 1482
Giraudeau, 1736
Girode, C., 340
Gironés, D. L., 504
Gisgnol, P., 1089
Giunta, A., 1085
Giusti, L., 1083
Gladstone, R. J., 923
Glaessner, K., 1743
Glaser, F., 1741, 1826
Glass, E., 930
Glassburg, J. A., *1196
Glasser, J. M., 1298
Gläsmer, K., 253
Glaus, A., 1403
Gleckler, A., 1993
Gleuny, A. T., 161
Gloyne, S. R., 751, 1735

Gmelin, E., 1157
Gobbi, L., 1482
Godel, R., 1573
Godfrey, E. S., Jr., 1064
Godin, P., 1481
Godoy, A. N., 167
Goebel, F., 1657
Goerke, M., 930
Goertz, 1152
Goiffon, R., 1303, 1481
Gold, E., 1659
Goldberg, B., 1405
Goldberg, M., 333, 1144
Goldberger, M. A., 576
Goldemberg, L., 427
Goldenberg, S., 1231
Goldie, W., 749
Goldman, A., 1893
Goldsmith, A. A., 334
Goldstein, H., 663
Goldthwaite, R. H., *628
Goldwater, S. S., 990
Goltwitzer-Meier, K., 587
Goltz, H. L., 1656
Gomes, E., 753
Gomez, L., 159
González, J. B., 505
González, S., 1484
González, Alvarez, M., 426
González Hurtado, R., 1483
González Mármol, D., 664
Gonzáles Olaechea, M., 68
Gonzalez Rincones, P., 166
Goodall, A., 825
Goodhart, S. P., 1475
Goodman, H., *701
Goodpasture, E. W., 747, 748, 1648
Goodrich, W. W., 1285
Goodwin, G. M., 745
Gordon, B., 1729, *1778
Gordon, C. A., 1630
Gordon, K., 1394
Gordon, O. A., Jr., *1021
Gordon, M. B., 421
Gordon, W., 1151
Gorter, E., 2150
Gosselin, R. L., *849
Gottlieb, A., *295
Gottlieb, J. G., 1405
Gottschalk, A., 251, 1901, 1902
Götzl, A., 1156
Goudman-Benstz, N., 1406
Goudriaan, J. C., 1744
Gougerot, H., 247
Gould, A. O., *693
Gould, W. L., 990
Gourdeau, A. E., 575
Gournay, 464, 1821
Gow, A. E., 1895
Goyena, J. R., 1085
Grabfield, G. P., 656
Grabich, F., 588
Grad, H., 1728
Gradle, H. S., *546, 1890
Grafe, E., 428
v. Graff, E., 756, 1308
Graham, A. J., 1001
Graham, D., 577, 1721
Graham, E. A., *613, 1224, *1777
Graham, G. F., 1572
Gralka, R., 1088
Gram, C., 1576
Gram, H. C., 1891
Grant, A. W., 1302
Grant, R. T., 1896
Grant, S. B., 336
Grantham, S. A., 1571
Grasser, O., 1309
Graves, E. H., 337
Graves, L. G., *1509
Graves, W. P., 497
Gravesen, J., 590
Gray, E., 1882
Gray, H., *628, 1649
Gray, H. M. W., 1146
Greco, N. V., 69
Greeley, P. N., *303
Green, N. W., 823
Green, O. I., *1517
Greenbaum, S. S., *88
Greene, C. H., 920
Greene, E. I., 334
Greene, I. W., 1570
Greenfield, J. G., 66
Greenwald, I., 1212, 1816
Greenwood, A., *92
Greenwood, A. M., *466
Gregg, H. W., *966
Grégoire, R., 340
Gregory, 757
Grellety-Bosviel, P., 163
Grenier, J., 340
Griesbach, H., 830
Griesbach, R., 2093
Griffith, F. R., Jr., 155
Griffith, J. D., *31
Griffith, J. P., 1645
Griffiths, H. E., 923
Grigg, W. K., *684
Grigsby, G. P., 419
Gripekoven, A., 586
Grober, 1089
Groedel, F., 1485, 1487
Groll, J. T., 170
Gröoel, 1901
de Groot, J., 1010
Gross, L., 824
Grossmann, M., 71
Groszmann, F., 2149
Grote, L. R., 667, 1902, 1903
Groves, R. L., 1648
Grueter, H. A., 169
Gruhalt, G. M., 2079
Grünbaum, A., 665
Grunenberg, K., 2149
Guccione, F., 1305
Gudzent, P., 1089
Guénard, 1822
Guerrero, L. E., 1804
Guerrero, S., 753
Guilbert, C., 1654
Guillain, G., 926, 1402, 1996, 2088
Guillaume, A. C., 1573
Guillaumie, 1821
Guilton, L., 1401
Guion, C. M., *1024
Guiou, N. M., *789
Guisez, J., 1996
Guiden, K., 1657
Gulland, G. L., 1150
Gumpert, M., 1087
Gundermann, W., 1487
Gunter, F. E., 1309
Günther, F., 505, 1902
Günther, H., 1827
Gurd, F. B., 577
Gurria Urgell, D., 2148
Guthrie, C. G., 747, 1147, 1395, 1730
Gutiérrez, J., 1824
Gutmann, A., 1008
Gutmann, B., 1991
Gutzeit, K., 664, 1089
Guy, C. C., *2119
Guy, W. H., 821
Guyer, M. F., 424
György, P., 1575, 1997

H

Haas, S. L., 1223
Haberda, A., 1903
Haberlandt, L., 72
Häberlin, C., 168
Habetin, P., 589
Hachen, D. S., 1474
Hackenthal, H., 2148
Haden, R. L., 417, 745, 1147, 1148, *1515, *1924
Haenmerli, A., 1084
Hage, 169, 1742
Hagen, G. L., *1933
Haggard, H. W., 1892
Haggard, W. D., 1470
Haggstrom, P., 1904
Haguenau, 425
Hahlo, C., 1657
Hahn, H., 665
Hailes, W. A., 338
Hailey, W. H., 2145
Haim, E., 1827, 1903
Haines, T. H., 497
Haines, W. D., 257
Hainiss, E., 1308
Hajek, J., 1077
Hajek, K., 2000
Hala, W. W., 580
Halbron, P., 1152
Haldane, J. B. S., 1302
Halford, A. C. F., 246
Hall, A. J., 1480
Hall, A. K., 1079
Hall, M. C., 918
Haller, D. A., 1731
Haller, E., 342
Hallion, 163
Halpert, B., 1658
Halphen, E., 927, 1152
Halstead, A. E., *1337, *1661
Hamburger, C., 1233
Hamburger, F., 589
Hamburger, R., 71, 167, 829
Hamburger, W. R., 59
Hamburger, W. W., *706
Hamlin, D. R., 975
Hammesfahr, C., 1157
Hammett, F. S., 331, 1816
Händel, 1088, 1232
Hanke, M. T., 1892
Hanneborg, O., 1893
Hannemann, K., 1742
Hannahan, E. M., Jr., 1147
Hansel, F. K., *15
Hansen, S., 430
Hansen, T., 1904
Hansmann, G. H., 2145
Hantcher, R., 585
Hanzlik, P. J., 336, *2001
Happ, W. M., 227
Hara, Y., 169
Harbin, R. M., 1810
Harbinson, C. H., 1727
Harbitz, F., 508
Harding, V. J., 924
Hardon, 424
Hardt, L. L., *692
Hare, H. A., 1138, 1631
Harkavy, *100
Harke, W., 831
Harman, F. W., *196
Harmon, G. E., 1295
Harrell, H. P., 1812
Harries, E. H. R., 1229, 1820
Harris, A., 2147
Harris, G. R., Jr., *1608
Harris, H., 337
Harris, J. W., 1730
Harris, R. H., 237
Harris, S., 1308
Harris, W. H., 922
Harrison, B. L., 1470
Harrison, G. A., 500
Harrop, G. A., Jr., 1892
Harrower, G., 1003
Hart, F. B., 243, 578
Hartman, C., 819
Hartman, F. W., *1196
Hartmann, 1654
Hartree, W., 660
Harvey, S. C., *1507
Harvey, W. F., 660
Harvier, P., 1573
Haskell, C., 1232, 1296
Haskins, J. B., 1390
Hassin, G. B., 497, 918, 1815
Hata, S., 1814
Hathaway, J. C., *1668
Hattesen, H., 1742
Hauck, 1090
Hauduroy, P., 424, 1152
Hauffe, G., 1999
Haughwout, F. G., 580
Hauke, H., 1574
Hausknecht, R., 584
Havens, L. C., 332, 1645
Haversmidt, J., 2150
Haxthausen, H., 539
Hay, J., 65
Hayem, G., 163
Haynes, L. W., 1818
Hazen, C. M., 499
Heald, C. B., 1995
Heaney, N. S., 240
Heath, H. J., 5*
Heatly, C. A., 334
Hecht, A. F., 1008
Heckmann, I., 1741
Heckscher, H., 346
Hedblom, C. A., 749, 823
Hedding, B. E., *1845
Hedinger, E., 249
Hedlund, E., 2000
von Hedry, N., 427
Heffernan, L. W., 1002
Heggie, N. M., *1044
Heggs, T. B., 65
Heidelberger, M., 61
Heidema, S. T., 831
Heidler, H., 1827
Heidrich, L., 1739
Heilbronner, F., 1999
Heilig, R., 1740, 2092
Heim, K., 1234
Heimann, E. A., 2150
Heimberger, H., 1086
Heine, L., 830
Heinemann, I., 1010
Heise, F. H., 333
Heitz, J., 339
Hejinian, L. M., 997
Hekman, J., 346
Hektoen, L., *949, 1892, 1893
Heller, S., 1308
Heilmann, J., 2149
Heilwig, A., 1086
Helmholz, H. F., 239, 1397
Helsley, G. F., *207
Hench, P. S., *1194
Hendelsohn, T., 72
Henderson, D. K., 245
Henderson, L. J., 1816
Henderson, M. S., 238, *945, 1649
Hendry, 1008
Henkel, M., 755
Henkes, K., 333
Hennebert, 586
Hennel, K. E., 1157, 2000
Henrichsen, K. J., 576
Henrichsen, S. L., 170
Henrijean, 1653
Henry, A., 1995
Henry, G. W., 2145
Hensch, 343
Henske, J. A., 579
Herbst, R. H., *1590
Herderschée, D., 507
d'Herelle, F., 826
Hering, E. E., 74
Herman, H., 2078
Hermann, A. G. J., 1576
Hernandez Briz, R., 1232
Hernández e Ibáñez, J. A., 1998
Herold, K., 1406
Herrera Vegas, A., 166
Herrick, W. W., 1731
Herrmann, G., 666
Herrold, R. D., *964, 1148
Hertzman, A. B., *1162
Herxheimer, H., 1234
Herzfeld, E., 343, 1084
Herzfeld, G. M. A., 1002
Herzog, F., 1658
Hess, A. F., 575, *952, *1604
Hess, F. O., 2091
Hess, J., 1656
Hess, W. R., 1007
Hesse, E., 1404, 1575
Hesse, M., 2093
Hetényi, G., 1234
Hetényi, S., 830
Heubner, W., 1902
Heuer, G. J., 576, 1467, 2080
Heuser, C., 505
Heusser, H., 70
Heveroch, A., 346, 1660, 2094
Heyd, C. G., 1728
Heyman, C. H., *1333
Heyman, H. V. J., 1652
Heymans, C., 1898
Heyn, L. G., *1019
Heynemann, T., 1009
Hibbs, R. A., 920
Hickl, J., 1743
Hicks, J. A. B., 1081
Higgins, T. T., 64, 925
Higgins, W. H., *599
Highman, W. J., 1393
Hijzer, H., 1575
Hildebrandt, G., 932
Hildebrandt, F. 1007
Hildebrandt, O., 1485
Hill, A. V., 660
Hill, H. W., 747
Hill, J. H., 157, *669, 1226
Hill, L., 1735
Hill, R., 237
Hillejan, A., 829
Hillis, D. S., 658
Hillkowitz, P., 1731
Himwich, H. E 1816
Hindhede, M., 430
Hingston, C. A. F., 245
Hinman, E., 1226
Hinman, F., *607, 822, 923, 2080
Hinton, J. W., 1645
Hinze, K., 252
Hirabayashi, N., 1824
Hirsch, E. F. 498
Hirsch, M., 1310
Hirschberg, 584
Hirschfelder, A. D., 1829
Hirst, J. C., *103, *296
Hirst, J. K., 1144
Hirt, W., 1574
Hishikawa, T., 1738
Hisinger-Jägerskiöld, E., 932
Hislop, J. G., 338
Hitzrot, J. H., 1642
Hjärne, U., 1158
Hiava, K., 346
Hoag, D. E., 1468
Hobbs, F. B., 247, 423
Hoeffel, G. N., 575
Hofbauer, J., 1009
Hofbauer, L., 1156
Hoffert, E., 1824
Hoffman, F. L., 1629
Hoffman, M. H., 1000
Hoffmann, E., 73, 345
Hoffmann, Heinrich, 830
Hoffmann, Hermann, 252, 506
Hoffmann, P., 1574
Hoffmann, V., 1574
Hoffmann, W. H., 158
Hoffstadt, R. E., 745
Hofmeier, J., 756
von Hofmeister, F., 428
Hofstee, J. P., 1406
Hogan, E. P., 234
Hoge, A. L., *788
Högler, F., 1234, 1486, 1743
Hogshead, J. McC., 1388
Hohlbaum, J., 1741
Holderman, H. H., *1927
Hollander, E., 1264
Holler, G., 1307
Holló, I., 1155
Holm, K., 1825
Holmblad, E. C., *1856
Holman, E., 658, *1045
Holman, W. L., 155
Holmes, M. J., 2086
Holmes, W., 230
Holmes, W. H., 1801
Holmström, R., 590
Holt, L. E., *1333
Holzbach, E., 507
Honeywell, H. E., 496, 997
Hoobler, B. R., 1570
Hoogslag, W., 1744
Hooker, C. B., 1225
Hooker, D., *55
Hooker, D. R., 495
Hooker, S. B., 243, 1077
Hoopman, F. W., 1897
Hoover, C. F., 655
Hopkins, B. E., 161
Horálek, F., 1576
Hörnicke, C. B., 1660
Hornung, R., 346
Horsfall, W. N., 1820
Horsley, J. S., *1159, 1393
Horsley, R., 2149
Horstmann y Varona, J., 1154
Hortolomel, N., 424
Horwood, M. P., 998, 1077
Hoseplan, Y. M., *542, *1104, *1504
Host, H. F., 430, 1828
Hotz, G., 2094
Houssay, B. A., 69
Houwer, 663
Howard, C. P., 1075
Howard, M. C., 1474
Howard, T., 1143, *1242, 1714, 1732
Howe, A. C., 1290
Howell, K. M., 1078
Howland, J., 158
Hoxie, G. H., *361
Hoyt, R. L., 1570
Hryntschak, T., 1659
Hu, C. H., *1254
Hubbell, E. Y., 1732
Hubbard, J. C., 1146, 1394
Hubbard, R. S., 920, *1342, 1889
Hubbard, S. D., 749
Huber, E., 1086, 1825
Hubert, G., 1485, 1487
Hübner, 587
Huck, G., 157, 747, 1730
Hudelo, 1655
Hudson, B., 1003
Huese, J. F. O., 1744
Huet, R. A., 1304
Hufnagel, J. J., 1850
Hulett, A. G., 1285
Hull, T. G., 333
Hundling, H. W., 1470, 1478
Hunneman, T., 2092
Hunner, G. L., *509
Hunt, J. R., 1475
Hunt, V. C., 237, 2081
Hunston, C. A., 1076
Hunter, J. W., 1650
Hurmuzachi, E., 1491
Hurst, A. F., 248, 823
Huster, L., 1234
Hutchison, R., 1895
Hutinel, 249
v. d. Hütten, F., 70
Hutton, J. G., *199, *868
Hutton, J. H., 1647
Hyman, A. S., 911
Hyman, H. T., 822
Hyslop, G. H., *1171

I

Ibrahim, A. B., 162
Ide, M., 1302
Igersheimer, J., 1826
Iglesias, M. S., 1901
Iglesias Garza, T. F., 251
Ikoma, T., 1405
Illert, E., 71
Livento, A., 165
Imbert, L., 163
Imre, J., Jr., 1890
Imrie, C. G., 583
Ingelfinger, F. J., 584
Ingerman, E., *759
Ingham, S. D., *17
Ingrao, C. E., 1305
Ingvaldsen, P., 999
Inlow, W. DeP., 745
Innes, A., 751
Irvine, H. G., 822, 1146
Isaac, S., 1902
Isaac-Kriegler, K., 252, 1741
Isaacs, H. J., 656
Isaacs, R., 1076, *1489, 2078
Isacsson, L., 922
Isbecque, G., 1573
Iser-Solomon, 1083
v. Issekutz, B., 1607
Italiener, K., 1740
Ito, H., 2092
Ivy, A. C., 997
Iyengar, K. R. K., 162
Izgur, L., *12
Izquierdo, J. J., 828, 1901
Izzo, R. A., 754, 1307

J

Jackson, A. S., 334, 1474
Jackson, C., *2027
Jackson, C. L., 1890
Jackson, H., Jr., 1891
Jackson, J. A., 333, *1058, 1992
Jacob, J. R., 1151
Jacob, L., 1999
Jacobaeus, H., 1406
Jacobi, H. G., 1232
Jacobson, A. C., *789
Jacoby, Adolph, 158
Jacoby, Arthur, 930
Jacoby, M., 427
Jacocks, W. P., *1601
Jacquemin, A., 2087
Jadassohn, J., 71, 427

Jaffe, H. L., 418
Jaffe, R. H., 1296
Jagic, N., 169, 931, 1743
Jahnel, F., 71
Jakob, A., 2092
Jakobovitz, 830
Jankowsky, W. D., 2149
Janku, J., 253
Janota, O., 1090
Jansen, B. C. P., 1828
Jansen, W. H., 1825, 1902
Janssen, T., 74
Janzen, 502
Jaquerod, 1900
Jarno, L., 1824
Jarrett, R. F., 1897
Jaur, 1822
Jáuregui, M. A., 68, 1900
Jeanselme, E., 1304, 1736
Jedlicka, Y., 253, 1235
Jeffrey, J. R., 1396
Jellinek, S., 345
Jenke, M., 1156
Jennings, F. L., 63
Jennings, J. E., 1644
Jensen, E. V., 346
Jensen, J., 1735
Jeudwine, W. W., 581
Jindra, Y., 1744
Joachimoglu, G., 666
Joachimsthal, R., 2092
Joannides, G. S., 827, 1090, 1828
Joannides, M., *1187
Joannon, P., 424, 1402
Joel, K., 1007
Joelson, J. J., 1001
Johannessen, A., 832
Johannsen, N., 1158
John, H. J., 418, 1226
John, J., 666
John, M., 1658
Johns, F. M., *1045
Johnson, F. P., 1226
Johnson, R., 411
Johnson, W. T., Jr., 498, 1395
Johnstone, I. N., 1395
Joland, 164
Joltrois, 927
Jomier, J., 752
Jonas, R., 73
Jonas, L., 59
Jones, A., 1642
Jones, C. L., 998
Jones, C. M., 156, 1991, 2078
Jones, C. P., 63, 1650
Jones, C. W., 1732
Jones, H. W., 924
Jones, J. F. X., 657
Jones, J. H., 243, 578
Jones, L. A., 147
Jones, M. R., *439
Jones, N. W., 59
de Jongh, S. E., 668, 1236
Jonnesco, T., 1083
Jordan, E. O., 1148
Jordan, H. P. B., *874
Josefson, A., 254
Joseph, D. R., 1071
Joseph, M., 1155
Josephson, E. M., *108
Josetti, R., 929
Joslin, E. P., 1887
Juarros, 251
Judd, E. S., *75, 236, 657, 1393, 1396, 1645
Judd, H. H., *1199
Juergens, H. M., *1342
Juge, 1303
Jumentié, J., 1304
Jundell, I., 1158
Jungermann, 72
Jungmann, P., 755, 1089, 1233
Just, E., 666
Juster, 826

K

Kaboth, G., 1739
Kabrhel, G., 1090
Kaess, F. W., 1087
Käfer, H., 1155
Kafka, F., 346
Kafka, V., 1658
Kagan, J. R., 1714
Kahler, H., 589
Kahn, G., *1933
Kahn, I. S., 227, *871, 1392, 1883
Kahn, M. H., *536, *1442, *1781
Kahn, Maurice, *1043
Kahn, Max, 495
Kaiser, A. D., 1639
Kalima, T., 1086
Kalk, H., 1307
Kalman, W. K., 253
Kaminer, G., 428
Kämmerer, H., 1827
Kane, E. O., 1714
Kaneko, J., 501, 1819
Kanner, O., 665
Kant, F., 665
Kanter, A. E., 658
Kaplan, I. I., 1086
Kappis, M., 506
Kapsinow, R., *9, *687
Karger, P., 2091
Karnosh, L. J., 922
Karr, W. G., 1226
Kartamischew, A., 1824
Kasahara, M., 1816, 2078
Kassowitz, K., 1486
Kast, L., *1858
Katib, A. E., 1302
Katz, G., 74
Katz, H., 1235
Katz, L. N., 1296
Katzenstein, M., 666
Kauf, E., 1659
Kaufmann, V., 758
Kawano, R., 253
Kayser-Petersen, J. E., 1308
Kaznelson, P., 170
Kearney, J. A., 1227
Keefer, C. S., 747, *1430
Keegan, A. F., 657
Keen, W. W., 147, *2027
Kehoe, E. J., *1845
Keidel, A., *2091, *528
Keilenburg, F., 2093
Keiller, V. H., 1300
Keim, H. L., 1813
Keiper, G. F., Jr., 1809
Keith, N. M., 1077, 1391, 1808
Keith, W. D., 1646
Keitler, H., 344
Kellaway, C. H., 1734
Kellbert, E., 746
Kellersberger, E. R., *1197
Kelley, E. R., 567
Kelley, S. F., 147
Kelley, T. H., *785
Kelly, H. A., 1300
Kelly, O. F., 2145
Kemp, J. E., *299, 1648
Kempmann, W., 850, 1089
Kennaway, E. L., 1572, 2087
Kennedy, F., 1815
Kermorgant, 341
Kerr, F. R., 2086
Kerrison, P. D., 1894
Kessel, L., 822
Kestner, O., 168
Ketron, L. W., 334
Kettle, E. H., 751
Key, B. W., *183
Keyser, L. D., *87
Khan, H. N., 1301
Kickham, C. D., 418
Kickham, C. J., 1729
Kiehne, H., 344
Kilduffe, R. A., 158, 1076, 1474, 1814
Kilgore, E. S., 1722
Kilgour, D., 1646
Killiam, J. A., 1728
Kimball, O. P., 1568
Kindberg, 1821
King, E. L., 1728
Kingery, L. B., 1477
Kingsbury, A. N., 1081
Kingsbury, B. F., 1078
Kinney, E. M., 1224
Kirby, G. H., 417
Kirchner, A., 822
Kirihara, S., 1487
Kirk, E., 59
Kirkbride, M. B., *1678
Kittel, P. B., 1897
Kjerruff, H., 430
Klaften, E., 253
Klarenbeek, A., 67
Klauder, J. V., *178, *933, 1475
Klaue, H., 343
Klee, F., 1486
Klein, H., 243
Klein, K., 2000
Klein, O., 589, 1903
Klein, W., 342
Kleinberg, S., 2081
Kleine, F. K., 587, 1575
Kleinmann, H., 1740
Kleinschmidt, H., 70, 167
Kleiweg de Zwaan, J. P., 1158
Klemensson, E., 1158
Klewitz, F., 1097, 1658
Kligler, I. J., 918, 1391
Klinkerfuss, G. H., *1247, 2146
Klopstock, A., 167, 588
Klopstock, E., 1485
Klopstock, F., 427, 587
Klotz, 1740
Kmietowicz, 1152, 1822
Knaggs, R. L., 64
Knapp, V., *1585
Knauer, J., 830
Knauer, W. J., *1044
Kneschke, W., 72
Knickerbocker, H. J., *1930
Knighton, J. E., 1993
Knoepfelmacher W., 1404
Knoll, W., 928
Knopf, S. A., 649
Knorr, M., 253
Knowles, R., 751, 1651, 2085
Knox, L. C., *1315
Koch, E., 170
Koch, H., 2090
Kodama, S., 1576
Koenigsberger, 1008
Koennecke, 72
Koessler, K. K., 1892
Kofoid, C. A., 918
Kogan, Y. M., 2091
Kohen, V., 1898
Köhler, A., 831
Köhler, F., 1089
Kohler, H., 169
Köhler, R., 1090
Kohlman, S. H., 1894
Kohn, F., 170
Kohn, J. L., 1473
Kolke, M., 1576
Kok, F., 1484
Koljubakin, 1086, 1487
Kolmer, J. A., 1146
Kondo, S., 588
Kondoleon E., 2087
König, E., 2092
Konjetzny, G. E., 1307, 1657
Konwiser, A. L., 1298
Koopman, J., 346, 508, 1233, 1488, 2150
Kopeloff, N., 417, 655
Kornfeld, F., 71
Körte, W., 1741
Korteweg, P. C., 1744
Koskowski, 1152, 1822
Koster, S., 668, 1744
Kosterlitz, E., 428
Kötschau, 1089
Kotzareff, A., 163, 165, 584
Kourilsky, 826
Kovárik, E., 1488
v. Kováts, F., 667
Kovjanic, R., 664
Kowarschik, J., 1309
Kragh, J., 932
Kramer, E., 343, 665
Kramer, H. F., *604
Kramer, P. H., 2150
Krasemann, E., 1308
Krasnig, M., 666
Kraul, L., 344
Kraus, F., 1901, 1902
Kraus, R., 666, 1308, 1486
Kraus, W. M., 1475
Krause, A. K., 1809, 1814
Krause, F., 344
Krause, H., 1234
Krause, W., 70
Krawkow, N., 1233
Krebs, O. S., 819
Krecke, A., 757, 931
Kredba, M., 1090, 1827
Kretschner, H. L., 62, 1732, *1850
Kretschmer, O. S., 1731
Kretz, J., 1486
Kreuter, E., 506
Kreutzer, H., 666
Kreutzmann, H. A. R., 1478
Kritzler, H., 1310
Kroeff, M., 426
Krogh, A., 70
Krogius, A., 829
Kroll, F., 342, 1741
Krömeke, F., 1155
Kronen, K., 1135
Kroó, H., 343
Kropatsch, A., 1008
Kross, I., 1295
Krüger, H., 507
Krüger, R., 1090
Krukowsky, O., 585
Krumbhaar, E. B., 2079
Krumwiede, C., 745
Krupnikoff, 1824
Krzyzanowski, G. 1152
Kubanyi, A., 2090
Kuczynski, M. H., 343, 1090
Kuenen, W. A., 254
Kugelmass, I. N., 1091
Kuh, S., *679
Kuhn, R., 1089, 1999
Kuhr, P., 1741
Kümmell, H., 71
Kummer, R. H., 340
Kunde, M. M., 1889
Kunz, J., 1742
Kurtzahn, 1658
Kusnetzowsky, N., 1741
Küster, E., 70
Küster, H., 427, 1992
Kuthy, O., 928
Kutscha-Lissberg, E., 2092
Kuttner, H., 1574, 2094
Kuttner, L., 1826
Kutzmann, A. A., 576, 998, 2080
Kylin, E., 168

L

Laache, S., 430
La Barre, J., 926
Labbé, M., 661, 1401, 1481, 1821, 1822, 1899, 1996
Labhardt, A., 827
Labin, B., 1154
Lacassagne, A., 1004
Lachman, G. S., *1861
Lackey, R. W., 155
von Lackum, H. L., *1109
Lacouture, J., 67
Ladd, W. S., 243
Ladin, A., 1898
Laemmer, M., 752
Laemmle, K., 1235
Laffont, A., 662
Lafora, G. R., 251, 2090
LaFrenais, H. M., 1652
de la Garza, J. U., 928
Lagos García, C., 1484, 1573
Lagrange, H., 1653, 1655, 1996
Laguesse, E., 1573
Lahm, W., 1085
Lahoz, J., 929
Laignel-Lavastine, 1006, 1304
Lajoier, J. M., 1894
Lake, R., 1400
Lake, W. F., *1023, 1811
Lal, N., 162
Lal, S. M., 581
Lamb, M. E., 2083
Lambert, A. V. S., 823
Lämel, C., 755
Lampé, L., 1575
Lampert, F. M., 1001
Lamson, R. W., *1091
Lamy, 1401
Landé, E., 1743
Lande, H., *1509
Landis, E. M., 1890
Landsteiner, K., 61, 1992
Lane, C. G., 1145
Lane, J. E., *852
Lane, W. A., 924
Lang, M. C., *2119
Lange, H., 830
Lange, K., 1825
de Langen, C. D., 668
Langenskiöld, F., 832
Langer, H., 666
Lankford, R. N., *468
Larimore, J. H., 1887
Larimore, J. W., 1145
Laroque, G. P., 236
LaRue, F. G., 419
Lasarjet, A., 249
Laubry, C., 1401
Lauche, A., 2091
Lauer, A., 2091
Laufberger, W., 1007
Laughton, N. B., 997
Laurens, H., 496
Laurka, 248
Lavedan, J., 1004
de Lavergne, V., 339
Lawen, A., 252, 1156, 1739
Lawmill, S., 1389
Lawrence, C. H., 1077
Lawrence, C. S., *25
Lawrence, J. S., *1252
Lawrence, R. D., 1479
Lawrence, W. S., 1390
Laws, G. M., *965
Lawson, G. B., 922
Lax, H., 1826
Lazarus-Barlow, W. S., 160
Leach, C. N., 580
Leake, C. D., *114, 656, 823, *1162, 1396
Leathers, W. S., 973
Lebert, 248
Leboucher, 661
Lecène, P., 1231
Le Chaux, 1821
Leconte, M., 1736, 1821
LeCount, E. R., 498, *1321
Ledebt, 163
Ledoux-Lebard, R., 1005
Lee, F. C., 997, 1396
Lee, W. F., 1845
Lee-Brown, R. K., 62, *607
Legangneux, 584
Legrain, 1006
Le Grand, 164
Lehman, E. P., *1918, 2146
Lehmann, E., 1574, 1744
Lehmann, F., 168
Lehmann, J. C., 1309
Lehmann, K. B., 831
Lehmann, W., 1902
Lehndorff, A., 170
v. Lehoczky-Semmelweis, K., 1659
Leichtentritt, B., 2148
Leighton, W. E., 238
Leimdörfer, A., 345
Leitzer, J. H., 429
Leipoldt, C. L., 1400
Leiri, F., 832
Leitz, T. F., 156
Leiva, L., 1079
Lejars, F., 1481
Lelcup, 1401
Lemaire, 1004
Lemann, I. I., 2146
Lemierre, A., 1737, 1821
Lemoine, A. N., *537
Lemon, W. S., 656, 1143
Lendon, A. A., 338
Lenfantin, H., 1821
Lenko, Z., 757, 1152
Lennox, W. G., 497, *602, 745
Lenormand, 1997
Lenormant, C., 1304
Lentz, C. S., 892
Lenz, E., 756, 1234
Leonard, G. F., *1679
Leonard, R. D., 1391, 1649
Leontjewa, L. A., 1086
Leopold, J. S., 1223
Leopold, S. S., 1474
Leo-Wolf, C. G., *2030
Lépine, J., 1152
Lepper, E. H., 1081
Lercche, W., 823
Lereluet, P., 339, 1303, 1402
Léri, A., 661
Leriche, R., 424, 585, 1230, 1655, 2088
Leroux, J., 927
Leshure, J., *631, 1065
Lesné, E., 1303
Lesser, 428
Letulle, M., 1303
Leucutia, T., 820
Leuiler, 1083
Levaditi, C., 1734, 1996
Léval, M., 1308
Leven, G., 67
Lévesque, J., 1737
de Levie, H., 668
Levin, A. L., 1227
Levin, J., 923
Levin, O. L., *465
Levine, J. G., *206
Levine, P., 243
Levine, S. A., 910, 1720, *1778, 1991, 2077
Levinson, P., 832
Levy, A. G., 1994
Levy, C. S., *1863
Levy, D. M., *375
Levy, M., 757, 1487
Levy, M. G., 1079
Levy, R., 424
Levy, R. L., 580
Levy, S., 70
Lévy-Franckel, 826
Levy-Lenz, 931
Lévy-Solal, 1401
Lévy-Valensi, J., 1737
LeWald, L. T., 823
Lewin, C., 566
Lewin, P., *32, 921, *965 *1177
Lewis, D. M., 748
Lewis, R., 997
Lewis, R. W., 241
Lewis, T., 1904
Lewis, W. H., 157
Lewisohn, R., 1815
Lewkowicz, K., 1821
Lhermitte, J., 1402
Lian, C., 1655
Libensky, 346, 2094
Lichtwardt, H. A., *652
Lichty, J. A., 745, 922, 1646
Lidström, A. E., 1010
Lieb, C. W., 1227
Liebe, W., 1485
Liebig, F., 1657
Liek, E., 1155
Liepmann, W., 1740
Lieschled, A., 2092
Lignac, P., 1655
Liljedahl, E. N., *2097
Linberg, B. E., 1657
Lindberg, G., 1223
Lindboe, E. F., 1310
Lindemann, W., 588
Linder, G. C., 578
Lindl, E., 63
Lino, G., 753
Linser, K., 1903
Lintz, W., 1149
Linzenmeier, G., 2000
Lipschütz, A., 1083
Lipschütz, B., 1486
Lipshutz, B., 1645
Lisk, H., 747
Liss, I. E., 575
Lisser, H., *1046
Liston, W. G., 1651
Litt, S., 1296
Little, C. C., 917, 1570
Little, C. F., 59
Little, E. G. G., 421
Littman, S., *868
Litzner, S., 757
Livingston, E. M., *1495
Li Virghi, E., 827
Li Virghi, S., 827

Livshis, L., 878
Lobo-Onell, 248, 1005
Lobstein, J., 1660
Lochrane, C. D., 246
Loebel, R. O., 1916
Loeper, M., 503, 662, 1153, 2088
Loeser, D., 1298
Loevenhart, A. S., 1477
Loewenstein, W., 1003
Loewi, O., 72, 1826
Löffler, E., 1743
Logan, J. F., 243
Löhr, W., 343
Lolr, A., 584
Loll, W., 253
Lombard, P., 502
Long, E., 1305
Long, M. L., 496
Long, W. B., 745
Long, W. H., 1217
Longcope, W. T., 1299
Lopez Albo, W., 341
Lorentz, E. H., 1089
Lorenzo, R., 663
Lortat-Jacob, 1006
Loschkarewa, 1087
Louros, N. C., 72, 507
Love, G. R., 336, 921
Lovelace, W. R., *457
Lovett, R. W., *171, *1115
Lovrich, J., 73
Löwenberg, K., 1658
Löwenborg, W., 2092
Löwenstein, E., 506, 1308
Lowenstein, P. S., *854
Lower, W. E., 1474
Lowsley, O. S., *270, *1011, 1477, 1644
Löwy, M., 73
Lozinsky, E., 496
Lubarsch, O., 1308
Lubin, D. S., 1079
Lublin, A., 1087
Lucke, H., 1146
Luckhardt, A. B., 997, *1603, 1732
Lucksch, F., 73
Lüders, E., 1657
Lüdke, H., 829
Ludlow, A. L., 1479
Ludium, S. D., 1297
Ludwig, F., 756, 1234, 1305
Luker, S. G., 925
Lullies, G., 1007
Lumière, A., 339, 1653
Lumsden, T., 660
Lund, F. B., 1394
Lundberg, S., 590, 1310
Lunde, N., 667
Lundy, J. S., *448
Lurie, M. R., 1144
Lurz, R., 930, 1658
Lusk, G., 1217
Lussana, S., 1305
Luten, D., 1077
Lütge, W., 2000
Luys, G., 1736
Lynch, F. J., 1570
Lynch, I. C. J., 1396
Lynch, J. F., *712
Lynch, J. M., *1929
Lynch, K. M., 918
Lynn, W. N., 1472
Lyon, D. M., 66, 335
Lyon, I., 1401
Lyon, M. W., Jr., *1863
Lyster, T. C., *17

M

Maas, O., 1088
Mabee, J., 243
MacAdam, W., 1727
McAlpin, K., 417
McBrayer, R., 420
MacBride, H. J., 582
McCann, W. S., 1642
McCarrison, R., 161, 660, 1300, 1651
McCarthy, J. D., 2083
McCartney, J. E., 335, 1395, 1648
MacCarty, W. C., 1000
Macciotta, G., 1232
McClean, D., 1651
McClellan, R. H., 748
McClelland, J. R., 244
McClendon, J. F., *1668
McClure, C. W., 919, 1146, 1991
McClure, W. B., *1425
McCluskey, K. L., 820
McCollum, E. V., 1225
McCord, C. P., *1104, *1759
MacCormac, H., 500
M'Cormick, D. D., 250
McCoy, G. W., 567
McCracken, J. C., 821
McCrae, T., 1809
MacCready, P. B., 917
McCrudden, F. H., *256
MacDonald, M. E., 582
MacDonald, W. J., 242
McEachern, J. D., 577, 2080
MacEachern, M. T., 974
McFarland, A. R., 1727
McGlannan, A., 234
McGlumphy, C. B., 1731, 2083
McGowan, F. J., Jr., 2080
MacGowan, G., 1226
M'Gowan, J. P., 1734
McGrath, B. E., 748
McGrath, J. A., 1301
McGraw, R. B., *2028
McGuire, S., 235
Macht, L. I., 62, 656, 1079
McIntosh, J., 1065, 1081
McKay, F. L., 1397
MacKay, H., 2081
McKenty, J., 1478
MacKenzie, D. W., 746, 1646
Mackenzie, L., 582
Mackenzie, J., 1228
Mackenzie, M. D., 338
MacKenzie, W. M., 64
Mackeprang, E., 1904
Mackie, T. J., 581
McKinley, E. B., 336, 417
McKinney, J. T., 258
Mackinnon, A. P., 1817
Maclaire, A. S., 1001
McLaughlin, L., 243
McLean, A., 336
MacLean, A. R. M., 998
Macleod, C. E. A., 1150
MacLeod, G., 578
Macleod, J. M. H., 1076
McLester, J. S., 1909, *2103
McMahon, A., 1078
MacMahon, H. E., 1814
McMaster, P. D., 999, 1396
MacNalty, A. S., 825
MacNeal, W. J., 1728
M'Nee, J. W., 824
McNeil, C., 750
McPhedran, A., 1146
MacPherson, G. T., *966
McPherson, R., 1728
MacRae, D. M., 1151
McVail, J. B., 64
McVicar, C. S., 158
McWhorter, G. L., 2146
McWilliams, C. A., 1630
MacWilliams, J. A., 500
Mader, A., 168, 2091
Maendl, H., 2093
Maes, U., *2007
Magat, J., 755, 2150
Magenta, M. A., 754, 1983
Magitot, 927
Maglione, R., 1306
Magni, Z. L., 1823
Magnus, G., 71, 830
Magnus, R., 663
Magrou, 1231
Maguire, G. C., 501
Maguson, P. B., 658
Mahler, P., 1485, 1575
Mahlo, E., 428
Mahood, C. I., 1080
Mair, W., 582
Maisin, J., 62
Maitland-Jones, A. G., 1302
Major, R. H., 655, 2082
Malis, J., 2090
Mallet-Guy, P., 1822
Malone, B., 1472
Malone, R. H., 660, 1652
Mandl, F., 71, 1657
Maner, G. D., 1226
Manfredi, L., 425
Mangineilli, L., 586
Mannaberg, J., 756
Manning, I. H., 891
Manning, W. J., *779
Mello Mano, N., 1084
Manouelian, Y., 1736
Manoukhin, I. I., 825
Manulla, S., 1402
Manwaring, W. H., *542, *1104, *1504
Marañon, G., 342, 1306, 1403
Marbury, W. B., *1684
Marchal, G., 2088
Marchand, L., 1655
Marchbanks, S. S., 1390
Marchesini, O., 753
Marchoux, E., 248
Marchey, W. J., 1396
Marcus, J. M., *1123
Marfan, A. B., 341, 425, 1004, 1230, 1823
Marie, A., 1898
Marie, P., 663
Marine, D., 1726
Marinesco, G., 423
Mark, E. G., *1689
Markel, C., 332
Markuse, K., 1574
Marmier, R., 1401
Marquézy, R., 2088
Marr, E., 169
Marrack, J., 160
Marraro, H. R., 251
Marriott, W. McK., 331
Marsh, H. E., 1145
Marsh, P. L., 1990
Marshall, E. K., 660
Martenstein, H., 1824
Martin, B., 507, 1657
Martin, C. F., 1721
Martin, C. L., 1391
Martin, J., 1822
Martin, J. F., 1230
Martin, K. A., 1988
Martin, L., 1898
Martin, P., 67
Martin, W., 1393
Martin Carrasco, T., 167
Martine, R., 827
de Martini, A., 928, 1823
Martini, P., 343
Martini, T., 426, 504, 754, 1154
Marty, 1898
Marvin, H. M., *1507
Marx, A. V., 1824
Marza, G., 1822
Marza, V., 1152
Mascheroni, 1403
Masmonteil, F., 340
Mason, E. C., 1225, 2083
Mason, E. H., 1394, 1725
Mason, J. M., 1393
Mason, N. R., 242
De Massary, 423
Massias, 339
Mastný, A., 1010
Matas, R., 499, 2080
Mathe, C. P., 62
Mather, J. R., 923
Mather, J. H., 659
Mathey-Cornat, 424
Mathieu, C., 1084
Mathieu, A., 926
Matsumoto, T., 344
Matsuno, J., 588
Matthews, H. B 1300
Mattick, W. L., 820
Matunovsky, I., 1486
Matzke, D., 332
Matzner, M. J., *1604
Mauriac, P., 1083
Maury, E., 1304
Mautner, H., 589
Maver, M. E., 576
Maxcy, K. F., 332
Maxwell, G. C., 496
May, J., 929
May, J. V., 418
Mayeda, T., 1087
Mayer, A., 344, 667
Mayer, E., *875, *1920
Mayer-List, R., 1999
Mayo, C. H., *624
Mayo, W. J., 1299
Mayou, F., 917
Mayr, J. K., 2000
Mazal, 1010
Mazepová, N., 1660
Meaker, S. R., 1077, *2098
Meakins, J., 1651, 1820
Means, J. H., 822, 1989
Means, P. H., 2078
de Medeiros, A., 1900
Meeker, D. C., 1042
Meeker, G. H., 891
Meeker, W. R., 656
Mehrtens, H. G., 242
Melchoir, E., 169, 342, 1086, 1739
Melen, D. R., *520
Meleney, H. E., 242
Mella, H., 1475
Melnikoff, A., 71
Mendel, B., 1574
Mendel, F., 1741
Mendel, J. H., 648
Mendel, L. B., 332, 578, 1224
Mendéléeff, P., 1898
Mendeloff, M. I., *1862
Mendenhall, W. L., 1078
Menetrier, P., 1400
Menon, V. K. N., 2085
Menschel, H., 830
Menti, S., 1904
Meo-Colombo, L., 2089
Mercer, W. C., 424
Merke, F., 1484
Merlini, A., 68
Merlo, 754
Merlo Gómez, J. F., 1574
Merriam, H. E., 1138
Merrill, E. F., *1833
Merrill, J. A., 578
Merritt, K. K., 1473
Mertens, G., 1827
Mertens, V. E., 1574
v. Mertz, W., 2000
Metis, F., 506
Meulengracht, E., 590, 1307
Meunier, L., 165
Meyer, E., 167, 663
Meyer, G., 1657
Meyer, K., 2092
Meyer, K. F., 498
Meyer, O. B., 170
Meyer, P. S., 830
Meyer-Bisch, R., 664, 665
Meyerding, H. W., 1649
Meyerhof, O., 1233
Mhaskar, K. S., 161
Michaelis, A. M., 1224
Michel, P., 1083
de Michele, P., 1006
Michon, L., 1231
Middleton, W. S., 746
Millan, G., 1153, 1482
Millinska, Z., 65
Miller, A. H., *1511
Miller, C. J., 234
Miller, C. P., Jr., *1028, 1988
Miller, E. L., 917
Miller, E. M., 658
Miller, H. E., 60, 2084
Miller, J., 66
Miller, J. A., 823
Miller, J. L., *1177
Miller, R. L., 1811
Miller, R. T., Jr., *1175
Miller, T. G., 1474
Mills, H. P., 497
Mills, H. W., 1478
Mills, L., 1295
Mills, W. G., 337
Milnor, G. C., *538
Miner, L. M. S., 1077
Minkowski, E., 1083
Minkowski, M., 663
Mino, P., 1006
Minot, G. R., *1489
Minster, D. K., *1104 *1759
Mitchell, H. H., 920
Mitchell, M. L., 1733
Mitchiner, P. H., 2085
Mixter, C. G., 235
Miyake, M., 501
Mocquot, P., 1084
Moeckel, K., 1999
Moench, G. L., *360, *1672
Moench, L. M., 1225
Moersch, F. P., 2145
Moersch, H. J., 656
Mohr, H., 832
Molitor, H., 428
Mollet, E., 1158
Moller, F., 2092
Molloy, D. M., 1392
Monckeberg, C., 1656
Monge, C., 341
Monod, G., 1819
Monrad-Krohn, G. H., 508, 1895
Monro, T. K., 1082
Montague, J. F., *788
Montague, O. C., 919, 1146
Montanari, U., 68
Montellano, J. J., 251
Montes Pareja, J., 1573
Montgomery, C. M., 576
Montgomery, J. C., 498
Montgomery, J. G., 1818
de Moor, 1822
Moore, A. B., 820
Moore, J. W., 1150
Moore, C. R., 998, 1391
Moore, C. U., 1732
Moore, H. L., 1398
Moore, J. E., *528, *2105
Moore, T. W., 923
Moore, W. F., *1036
Moore, A. W., 162, 1400
Moos, E., 1087
Mooser, H., 1648
Morales Villazon, N., 250
Morgan, A. F., 1889
Morgan, G., 246
Morgan, H. J., 1148
Morgan, N. D., 1478
Morgenroth, J., 665
Mori, S., 1819
Moriarty, M. K., 575
Morichau-Beauchant, R., 163
Morin, P., 164
Morison, A. E., 1895
Morison, D. M., 1226
Moritsch, 506
Morley, J., 1399
Moro, E., 428, 1404
Morquio, L., 426, 828
Morris, L. M., 1813
Morris, R. E., 63
Morris, R. S., 59
Morriss, W. H., 820
Morrisson, T. H., 1143
Morrow, H., 240
Morse, P. F., 1729
Morsman, C. F., *1750
Mortimer, E., 1146
Morton, D. J., 920, 1817
Moser, E., 1406, 2091
Mosier, K., 1575
Moss, M. N., *2118
Moss, O. W., *1442
Mossé, S., 1231
Motley, J. C., 1149
Motta, L. C., *85
Mottram, V. H., 1400
Motzfeldt, K., 74
Moubarak, E., 1151
Mougeot, A., 162
Mouradian, H., 1736
Mouriquand, G., 752, 1083
Moynihan, B., 1399
Much, H., 1485
Mudaliar, A. L., 245
Mudge, C. S., 498
Mueller, J. H., 578
Mueller, O., 1999
Muench, H., *33
Mufson, L., 335
Muggia, A., 828
Muhl, G., 1236
Mühlens, P., 505
Muir, E., 162, 581, 1002
Mukerji, A. K., 1572
Mulherin, W. A., 1811
Müller, E., 342
Müller, E. F., 73, 1156
Müller, F., (Frankfurt), 931
Müller, F., (Munich), 410
Müller, G., 1235, 1744
Müller, G. G., 1810
Muller, G. P., *1852
Müller, H., 343
Müller, L., 1898
Müller, O., 1089
Müller, W., 427
Mulligan, P. B., *791
Mulzer, P., 344, 756
Munck, W., 254
Mündel, F., 931
Munro, H., 812
Munford, S. A., 1889
Munlogurria, C., 929
Munk, J., 2150
Murawski, E., 584
Murayama, K., 2082
Murlin, J. R., 1889
Murphy, D. P., *784
Murphy, J. B., 62
Murphy, W. P., *425, *1264, 1989
Murray, G. M., 2145
Murstad, E., 1310
Musser, J. H., 756, 820
Mutschler, R., 1824
Myers, B. D., 1072
Myers, C. N., 240, 1075, 1813
Myers, V. C., 1382, *1858, 1892

N

Naegeli, 341
Nafziger, H. C., *1751
Nagell, H., 664
Nageotte, J., 1821
Nagy, E., 1089
von Nagy, G., 1007
Nakamura, T., 821
Nanta, A., 1737
Napier, L. E., 245
Narabayashi, T., 501
Nassau, E., 72, 829, 1088
Nather, K., 931, 2094
Naujokks, H., 756, 1658, *1692, 1827
Nauth, W. W., *1692
Navarro, A., 250
Navarro, J. C., 69
Neal, P., *1429
Neff, F. C., 917
Negus, V. E., 582
Neligan, A. R., 583
Nellis, L., 1087
Nelson, L. A., 2080
Nelson, M. T., 243
Nelson, R. F., *190
Nepveux, 1822
Nesbitt, G. E., 1995
Nesmejanow, A. N., 344
Netter, A., 926, 2087
Neubauer, B. B., 1645
Neuberg, C., 251
Neubürger, K., 344
Neuburger, M., 253
Neuda, P., 253
Neufeld, F., 587
Neumann, R. O., 71
Neumann, W., 1305, 2093
Neurath, R., 1155, 1156
Neuschlosz, S. M., 665, 1741
Neustaedter, M., 580
Neuwirt, K., 429
Neve, E. F., 162
Nevermann, H., 71, 755
Nevin, M., 1648
Newburgh, L. H., 417, 1146, 1990
Newman, R. H., 1389
Newsam, A. R., 1397
Newton, F. C., 822
Nicati, W., 661
Nichelatti, P., 1998
Nicholls, A. G., 747
Nicholson, F. M., *545
Nicod, J. L., 1084
Nicodim, E., 1401
Nicolaeff, L., 249
Nicolau, S., 926, 1996
Nicolesco, I., 210
Niedermeyer, A., 2091
Niehaus, F. W., *547

Niemeyer, R., 737
Niles, G. M., *967
Niles, W. L., 1887
Nin y Silva, J., 426
Nitzescu, I. I., 1401
Nixon, J. A., 751
Nobak, G. J., 331
Nobécourt, P., 1153, 1304, 1402
Nobel, E., 666, 1659
Nobl, G., 344, 1575
Noble, B. E., 332
Noble, J. F., *1410
Nobre, A., 1085
Noguchi, H., 63, 1391
Noguera Gomez, E., 166
Nord, G. H., 1576
von Norden, C., 1902
Nordenson, J. W., 590
Normet, 502
Norrie, G., 832
Norris, C. C., 657, 2079
Norrlin, L., 589
Norvig, J., 1744
Nothmann, M., 169, 1740
Notkin, M., 655
Nourse, J. D., 917
Novak, E., *1664
Noyons, K., 1230
Nublola, 662
Nürnberger, L., 1085
Nyiri, W., 1009
Nyulasy, F. A., 924

O

Oberhelman, H. A., 997, *1321
Ocaranza, F., 828, 1483
Ockel, G., 342, 1308
O'Connor, J. M., 1301
O'Connor, M. F., 497
Odalra, T., 1156
Odermatt, W., 71, 165, 1900
Odier, C., 1305
O'Donnell, F. J., 1480
Oehler, 1309
Oeller, H., 167
Oertel, H., 1652
Offergeld, 1085
Ogata, S., 1904
Ogata, T., 1901
O'Hare, J. P., 1144, 1296, 1815, 1888
Ohly, A., 73, 1155
Ohnawa, 2148
Ohta, K., 591
Olle, J. A., 1721
O'Keefe, E. S., 1224
Okubo, K., 1158
O'Leary, P. A., 1393
Olin, E. M., *1228
Olitsky, P. K., 335, 1305
Oliver, J., 1297
Oliver, T., 1995
Olsen, T., 68
Oltramare, 1004
Oltramare, H., 1997
Oltramare, J. H., 1997
Ophüls, W., 417
Opitz, E., 74, 428, 667, 831, 1741
Opitz, H., 1902
Oppenheimer, B. S., 1722, 2077
Oppenheimer, R., 1487
Oppenheimer, R. H., *1685
Oppenheimer, W., 588
Orator, V., 736, 1659
O'Reilly, A., 1000
O'Reilly, W. F., *631
Ornstein, G. G., 576
Orr, E. G., 238, 745, 1147, 1148, *1515
Osborne, O. T., 2137
Osborne, T. B., 578, 1224
O'Shea, R. J., 1397
Oslund, R., 406, 998
Osman, A. A., 1003
Osmond, T. E., 1651
Ostrcil, A., 346, 1009
v. Ott, D., 169
Ott, W. O., 1000
Otten, L., 668
Otto, K., 755
Ottow, B., 1235
Oudard, M., 1004
Oudendal, 1828
Oury, P., 165, 248, 661
Owen, B. A., 1630

P

van Paassen, P., 1236
di Pace, L., 425
Pacheco, G., 1822
Pack, G. T., 1991
Paddock, B. W., *1855
Paderstein, 70
Padua, R. R., 1731
Page, H. N., 420
Pagenstecher, G. A., *1692
Pagniez, P., 662
Painton, G., R., 245
Paisseau, G., 1083
Pal, J., 1743
Palazzo, R., 1306
Palmer, C. B., 746
Palmieri, V. M., 1656
Panayotatou, A., 1653
Panis, G., 1482, 2088
Pannett, C. A., 1151
Panton, P. N., 1302
Papacostas, 1401
Papin, E., 1083, 1731
Papin, F., 1004
Paraf, J., 164, 339
Pardee, H. E. B., 1149
Pardo-Castello, V., 1076, 1998
Parhon, C. I., 1152
Parl, G. A., 1483
Park, W. H., 567
Parker, F., Jr., 2083
Parra, R. F., 1484
Parrisius, W., 1086, 1233
Parry, R. H., 160, 1081
Parsons, H. T., 1892
Parsons, J. P., 1396
Parsons, L. G., 1652, 1820, 2147
de Partearroyo, F. R., 930
Parturier, G., 1152, 1821
Pascal, C., 1304
Paschkis, K., 72
Pasterny, K., 1485
Patch, F. S., 999
Paterson, D., 66
Patrick, H. T., *375
Patterson, R. F., 1470
Patterson, R. V., *453
Patterson, S. W., 247, 824
Pattison, C. L., 584
Pauchet, V., 584, 1230
Paul, S., 931, 1308, 1404
Paul, T., 1487
Paulesco, N. C., 1822
Paulli, W. E., 74, 589
Paullin, J. E., *762
Pavlovic, R., 664
Payne, F. L., *106
Payne, R. L., 235
Payne, W. H., *546
Payne, W. W., 66
Peabody, F. W., *963, 1808, 2078
Pearce, J., 1081
Pearce, L., *5, 1992
Pearl, R., *259
Pecegueiro, A., 1998
Peck, C. H., 235
Peck, E. C., 1479
Pegge, A. V., 1301
Peiper, A., 1307
Peiser, 1485
Pelc, H., 346
Pélissier, R., 1304
Peller, S., 253
Pelnár, 1576
Pels Leusden, F., 73, 1485
Peltesohn, S., 1659
Pemberton, R., 1988
de Pena, P., 2089
Peple, W. L., 1656
Pepper, O. H. P., 1071, *1632, 1726
Peralta Lagos, S., 587
Peralta Ramos, A., 1373
Pereira, F. E., 1150
Péres, 1736
Perez, M. L., 250, 505
Pergola, M., 1153
Peritz, G., 1307
Perkins, G. A., 1080
Perman, E., 2000
Péron, N., 661
Perrin, T. G., 2148
Perroncito, A., 1483
Person, W. E., 1810
Perthes, G., 1309, 1658
Pesetke, S. E., 1477
Peshkin, M. M., *1854
Pessel, J. F., 1147, 1395, 1730
Petényi, G., 427, 1826
Peter, L. C., 1388
Peters, J. P., 1909
Peters, J. T., 928
Petersen, E., 346, 1488
Petersen, O. H., 2149
Petersen, W. F., *2139
Petit-Dutaillis, D., 502
Petow, 1090
Petren, K., 1646
Petroff, S. A., 345
Petschacher, L., 345
Petzetakis, 1734
Petzold, J., 756
Peyrer, K., 429
Peyrer, R., 2093
Pézard, A., 1653, 1898, 1904, 2000
Pfahler, G. E., 1398
Pfanner, W., 1089
Pfaundler, M., 344
Pflüger, H., 2093
Phaneuf, L. E., 499
Phelan, G. W., 1001
Phelps, B. M., *1254
Phelps, O. D., 919
Phemister, D. B., *1311, 1817
Philibert, A., 424, 503, 1005
Philip, R., 1229
Philipp, E., 72
Phillips, H. B., *27, *31, *1847
Phillips, P., 659
Phipson, E. S., 245
Photakis, B. A., 1740
von Phul, P. V., 1397
Piattelli, A., 2089
Picazio, A., 1232
Piccaluga, N., 753
Pichler, J., 1743
Pick, A., 2150
Pick, E., 1007
Pick, E. P., 428, 1825
Pickhardt, O. C., 823
Pico, C. E., 250
Pidcock, B. B., 1229
Pierce, B., 1820
Pieri, G., 663
Piery, M., 247
Pietra, P., 1305
Piga, 167
Piguet, 1737
Pijper, A., 501
Pike, H. V., 333, *1098
Pilcher, J. D., 921, 1729
Pilot, I., 333, 658
Pinali, R., 425
Pinard, 502
Pinard, M., 423
Pinchin, A. J. S., 751
Pineda, E. V., 1149
Piney, A., 1081, 1734, 2085
Pinkham, C., 1147
Pinkus, F., 169
del Pino, P., 250
Pi Suñer, A., 1654
Plass, E. D., *266
Platou, K. E., 74, 589
Platt, H., 1081
Plaut, F., 344, 756
Plaut, R., 1484
Player, A. P., 62
Plehn, 930
Plesch, J., 1087
Plummer, H. S., 919
Podlaha, J., 429
Podrouzek, V., 2094
Poeck, E., 169, 1742
Pogorschelsky, H., 829
Pohl, A., 2091
Polak, O., 1001
Polettini, B., 663
Polgar, S., 1660
Poliakoff, S., 1576
Policard, A., 248, 425
Pollak, L., 666
Polleri, P. M., 165
Pollet, 164
Pollice, F. R., 1998
Pollitzer, R., 663
Pollock, L. J., 1300
Pompeani, 826
Ponce de Leon, M., 68
Pontano, A., 1656
Pool, E. H., 2080
Popescu-Inotesti, C., 1488
Popoviciu, G., 1402
Poppi, A., 828
Porges, H., 1486
Porges, O., 168, 930
Porter, A., 923
Porter, C. A., 1300
Porter, D. P., *1504
Porter, J. L., *32
Portis, B., 1078
Portu Pereyra, E., 2090
Pototzky, C., 1008
Pottenger, F. M., 156, 1079, 1143
Pötzl, O., 73, 506
Poulsson, 1231
Poulton, E. P., 66
Poyarkoff, E., 1898
Poynton, F. J., 925
Pozerski, E., 1481
Pozzo, F., 251, 1155
Prado Tagle, E., 1154
Praetorius, G., 1744
Praguer Frões, R., 1823
Pratt, D., 426, 1900
Pratsicas, A., 1828
Prausnitz, C., 828
Precechtel, A., 253, 1310
Prentiss, A. M., 656
Presser, K., 1009
Pribram, B. O., 251, 1825
Pribram, H., 1903
Price, G. E., *1251
Priest, W. S., Jr., 55
Priestley, J. B., 332
Printy, E. A., *1779
Prior, C. E., 972
Pritchard, J. E., 716
Propst, D. W., *2102
Protti, G., 68
Pruitt, M. C., 1812
Prusik, B. K., 824, 1235, 1744
Pruska, 1010
Pryde, J., 1002
Psaraftis, 585
Puche, 1654
Pucher, G. W., 921
Puech, 1153
Pugh, W. S., *1011
Puig, J., 1997
Pulay, E., 2150
Pulido, A., 2090
Pullelne, R. H., 338
Punton, V., 1153
Puppel, E., 1742
Pusey, W. A., *1905, 1960
Putzig, 1487

Q

Quain, E. P., 238
Quaranta, L., 1154
de Quervain, F., 752
Quesada Pacheco, R., 504
Quick, W. J., 1391
Quigley, D. T., *2029
Quiroga, M., 929

R

Raab, W., 72, 1486
Rabinowitch, I. M., 417, 999, 1646, 2081, 2083, 2086
Rabinowitsch-Kempner, L., 74
Rabl, C. H., 1009, 1827
Rabut, 1655
Rachet, 423
Radelet, 1230
Rademaker, G. G. J., 663
Raeder, J. C., 490
Rahm, H., 930, 1739
Raimann, J., 2149
Rakusin, M. A., 344
Ramadier, J., 927
Ramais, P., 163
Ramakrishnan, P. S., 2085
Ramaley, F., 1461
Ramirez, E., 1647
Ramirez, M. A., 657
Ramon, G., 502, 1004
Ramond, L., 1737
Ramsay, G. W. C., 1895
Ramsbottom, A., 1228
Randall, A., 419
Randles, F. S., *684
Randolph, V., *442
Rankin, H. P., *457
Raoul, 661
Rasch, C., 1994
Rasmussen, H. K., 758
Rathbun, N. P., 419, 1300
Rathery, F., 164, 826, 1654, 1821, 996
Ratner, B., 819
Rauch, I., 1235
Raunert, M., 2060
Rautmann, H., 757
Ravdin, I. S., *1852
Raven, M. O., 338
Ravenel, M. P., 568
Ravina, A., 164
Raw, N., 1819
Rawson, V., *545
Raykowski, W., 1309
Raymond-Hamet, 1152
Razetti, L., 69, 1484
Read, B. E., 1082
Read, J. S., 922
Reasoner, M. A., *1691, 1813
Rebaudi, U., 165
Reber, M., 1232
Rech, W., 1088
Recht, G., 2149
Redlich, E., 1008
Redlich, F., 253
Reeder, J. E., *815
Reenstierna, J., 584
Reese, A. B., *1593
Reese, R. G., *614
Regaud, C., 248, 1005
Regnier, E. A., 1477
Rehm, M., *1759
Reichle, F., 252, 756, 1088
Reid, W. D., 655, *1040, 1815
Reifferscheid, K., 1310
Reijnders, F. H. H., 832
Reimann, S. P., *2115
Reinhardt, L., 2093
Reinhold, C. H., 581
Reinwein, H., 1825
Reis, R. A., *526
Reiter, T., 1090
Reith, A. F., 1148
Reitler, R., 1309
Remlinger, P., 1152
Rémond, A., 1996
Renaud, M., 1231, 1303
v. Renesse, H., 664
v. Renner, S., 1309
Renton, M., 500
Replogle, D. E., *387
Reschke, K., 1156, 2092, 2149
Réval, I., 1743
Reyher, P., 930, 1487
Reymann, J., 73
Reyner, C. E., *196
Reynolds, C. E., 2069
Reynolds, E. S., 560
Reynolds, L., 1991
Reynolds, M. S., 1892
Rhein, J. H. W., 1475
Rhoden, R. L., 236, *1752
Ribbow, M., 1824
Ricaldoni, A., 1821
Riccitelli, E., 166
Richard, A., 1304
Richard, G., 1656
Richardson, C. H., Jr., 1810
Richardson, F. H., *113
Richardson, H. B., 156
Richardson, J. J., 1815
Richardson, W. W., 60
Richet, C., 249
Riddel, D. O., 582
Riddle, O., 496, 997
Riddoch, G., 1202
Ridler, H. A., 1302
Riebold, G., 1233
Rieger, K., 1405
Riesman, D., *1256
Rietschel, 167
Rietti, C. T., 1083
Rifkin, P., *1596
Riggs, T. F., 245
Riggs, T. F., 238
Rimbaud, 1153
Ringer, M., 578
Riser, 1736
Risquez, J. R., 69
Ritossa, P., 1305
Rivarola, R. A., 426
Rivers, T. M., 335, 2082
Rivière, M., 1231
Roberts, C. S. L., 64
Roberts, C. W., 1810
Roberts, E. H., 1814
Roberts, F., 661
Roberts, H. C., 1399
Roberts, L. J., *622
Roberts, S. R., 1389, 1811
Robertson, G., 1002
Robertson, H. O., *717
Robertson, O. H., 1147
Robertson, R. C., 1648
Robin, 1822
Robins, C. R., 235
Robinaki, 1088
Robinson, E., *1675
Robinson, E. S., 242
Robinson, G. C., 1808
Robinson, H. J., *528
Robinson, W. H., *1935
Robitschek, W., 252
Roch, M., 1482, 1997
Rochat, R. E., 249
Rocher, 1655
Rockwood, R., 241
Rodiet, A., 1737
Rodman, J. S., 1645
Rodrigo, J., 1483
Rodriguez, Jose, 1080
Rodriguez, Juan, *203, 1816
Rodriguez, O. L., 753, 929
Rodriguez, Pedro V., 1085
Roedelius, E., 506
Roeder, C. A., *517
Roello, G., 663
Roemer, P., 1659
Roessingh, J., 1826
Rogers, F. T., 155, 1391
Rogers, L., 1150
Rohdenburg, E. L., *200
Rohr, J., 1905
Rojas, H. M., 663
Rolleston, C., 1735
Rollier, A., 1144
Romani, L., 928
Romano, N., 504
Romberg, E. C., 1476
Romieu, M., 1822
Rominger, E., 1659
Romiti, C., 1084
Ronchese, A. D., 826
Ronchi, A., 1006
Rongy, A. J., 1144
Rood-Smid, J. A., 1236
Roos, J., 1896
Rosanoff, A. J., 497
Rose, G., 586
Rose, M. S., 578
Rosen, I., 1075, 1394, 1813
Rosenau, M. J., 567
Rosenau, W. H., *547
Rosenbaum, B. N., 1309
Rosenbaum, C., *2119
Rosenberg, M., 665, 1485
Rosenberg, W., *682
Rosenblum, P., 1473
Rosenfeld, S., 1732
Rosenfeld, H., 252
Rosenheck, C., *27
Roseno, A., 1235
Rosenow, E. C., 244, *449, 918, 1648, 1988
Rosenson, W., 239
Rosenstein, 1742
Rosenthal, G., 340
Rosenthal, N., 417, 1990
Rosenthal, O., 1088

Roskam, J., 249
Ross, H., 158, 920
Ross, J. H., 579
Ross, S. G., 2079
Rossello, H. J., 753
Rossi, R., 754
Rost, G. A., 588
Rostand, J., 1898
Rostenberg, A., *207
Roth, L. J., 998
Roth, O., 757
Rothberg, V. E., 336
Rother, J., 2150
Rothman, P., 1147
Rothman, S., 71
Rothschild, M. A., 1722
Rotky, H., 1999
Roubinovitch, J., 1655
Rouget, J., 937
Rous, P., 999, 1396
Roussel, J., 1482
Roussiel, M., 2088
Roussy, B., 902
Roussy, G., 1006
Roux, J. C., 1303, 1431
Rouzaud, 925
Rovsing, T., 74, 1284
Rowe, A. H., 418, *1168
Rowland, A. F., 1225
Rowland, V. C., *372
Rowntree, L. G., 1886
Roxas, B., 1227
Roy, D., *268
Royle, N. D., 1082
Royster, H. A., 1398
Rreifuss, W., 2090
Rubeska, V., 589, 1010
Rubino, 108
Rucker, G. E., 1296
Rucker, M. P., 499, 575, *870, 1232
Ruddock, J. C., *1682
Rueda, P., 426
Rueda V., M. A., 1484
Ruediger, E. H., 820
Ruge, C., Jr., 1738
Ruggles, H. E., 1813
Ruh, H. O., 244
Rühle, R., 1155
Rumpf, F., 1404
Runge, H., 507, 2091
Runge, W., 1484
Rupel, E., 1078
Rushmore, S., 892
Rusk, G. Y., 241, *442
Russell, E. C., *1775
Russell, N. G., 1641
Rustia, G., 1227
Rutherford, A., 66
Rutherford, A. G., 1571
Rutkowski, J., 425
Rychlik, 1010

S

Saalfeld, E., 2150
Saathoff, L., 1659
Sabatini, G., 1305
Sabatini, L., 1006
Sabrazès, J., 339, 534
Sachs, A., 1474
Sachs, H., 167, 588
Sachs, M., 931
Sacquépée, E., 424
Sadolin, F., 1496
Saelhof, C. C., 1814
Saenger, H., 1485
Sætbre, H., 1090
Sagel, 1575
Sahler, A., 1743
Sahlgren, E., 832
Sahli, H., 51, 170, 798
Saidl, J., 1010
Saier, 1080
St. George, A. V., 657
de Saint-Martin, 927
Sainz de Aja, E. A., 822, 1998
Saito, Y., 1155
Sajous, C. E. de M., 1991
Salazar, G., 1149
Salén, E., 932, 1828
Salen, G., 1232
Salkindsohn, O., 1157
Salle, 339
Salmon, 1482
Salomon, A., 168, 1097, 1487
de Salterain, J., 426
Salthe, O., 745
Saltzstein, H. C., 2140
Salus, C., 1308
Saltvesen, H. A., 578
Samengo, L., 167, 504
Sampson, J. A., 1299
Samson, J. W., 666, 2091
Samssonow, N., 1095
de Sanctis, C., 505
Sand, 1653, 1904, 2000
Sander, F. V., 242
Sander-Larsen, 1576
Sanders, J., 1010
Sanders, L. C., 1471
Sandiford, K., 920
Sandor, J., 71
Sands, J., 332
Sanford, A. H., 241, 1225
Sanger, H. F., 992
Sano, M., 1157
Sansum, W. D., 418, 1476
Sant'anna, J. G., 1403
Santenoise, 927
Santoro, E., 1006
Santos, J. E., 1484
Sarnoff, J., 576
Sartorius, F., 1485
Sasano, K. T., 1814
Satke, O., 664
Saunders, A. M., 1298
Sauphar, J., 1899
de Saussure, R., 1152
Savariaud, M., 1097
Savatard, L., 1475
Savignac, R., 585, 1231
Sawicki, B., 1230
Sawyer, H. P., *764
Sawyer, W. A., 655
Saxl, P., 428
Sayé, L., 2148
Sayre, R. H., *1691
Scabell, A., 2092
Sceletb, C. E., *679
Schachenmann, H., 2149
Schade, H., 756
Schäffer, H., 667
Schaltenbrand, G., 1007
Schamberg, J. F., 822, *1911
Schanz, A., 252
Scheer, K., 168
Scheinfinkel, 2092
Schenk, P., 1999
Scheppegrell, W., 1079, 1714
Scherzer, M., 1088
Scheunert, 342
Schick, B., 1568
Schickelé, G., 1304
Schierbeck, N. J., 74
Schiff, E., 254, 1405
Schiff, F., 1826
Schiff, N. S., 59
Schilf, E., 1155
Schilf, F., 828
Schilling, C., 2148
Schilling, E., 167, 1981
Schilling, V., 343, 1090
Schinz, H. R., 1307
Schipper, 170
Schlaepfer, K., 1143, *1581
Schlayer, C. R., 757
Schlesinger, H., 429, 1486, 1826
Schlesinger, M. J., 748, 1647
Schlomovitz, B. H., *1845
Schlossmann, A., 665
Schmid, H. H., 253, 1085, 1826
Schmidt, C. L. A., 578
Schmidt, F., 1654
Schmidt, H. R., 588
Schmidt, M., 1299
Schmidt, M. B., 1405
Schmidt, P., 253, 665, 1084
Schmidt, R., 252
Schmidt, V., 254
Schmidt, W., 2093
Schmieden, Y., 758
Schmincke, A., 589
Schmitt, L. S., 976, 1074
Schmitt, W., 1235
Schmitz, E., 505
Schmitz, H. W., 1297, *1853
Schnabel, A., 1740
Schneider, E., 1009
Schneider, G. H., 1742
Schneider, H., 1650, 1899
Schneider, M., 74
Schöbl, O., 1080, 1149
Schoen, 1996
Schoenholtz, L., 507
Scholl, A. J., *75, 236, 657, *688, 1001, 1393
Scholz, 428
Schönbauer, L., 756, 1743, 1903
Schönfelder, T., 339
Schoonmaker, H., 1729
Schoonover, F. S., Jr., 1228
Schott, E., 1825
Schramm, 1744
Schrankel, R., *2028
Schreuder, O., 1236
Schreus, H. T., 345
Schroder, C. H., *686
Schroeder, L. C., *1916
Schteingart, M., 1656
Schubert, J., 505
Schüffner, W., 254
Schugt, P., 507
Schulhof, K., 1892
Schüller, M. P., 1739
Schulmann, E., 1402
Schultz, T., 2090
Schultze, F., 1903
Schulz, 343
Schüppel, A., 2149
Schurmeier, H. L., *302
Schwab, 423
Schwalbe, J., 829
Schwartz, 2093
Schwartz, C. W., 1297
Schwartz, L., 1084
Schwartz, P., 1234, 2149
Schwartz, R. P., 921
Schwarz, E., 503
Schwarz, G., 429
Schwarz, H., 1223
Schwarz, O. H., 2079
de Schweinitz, G. E., 899
Schweizer, F., 341, 754
Schweizer, R., 1403
Schwenson, C., 1236, 1576
Schwoerer, B., 1739
Scott, C. M., *1193
Scott, C. R., 498
Scott, D. A., 1889
Scott, G., 1081
Scott, H. H., 337
Scott, J. A., 924
Scott, J. M. D., 661
Scott, R. A., 1478
Scott, R. W., *1417, 1807
Scott, W. H., 825
Scott, W. J. M., 61, 1396
Scott, W. R., *623
Secher, K., 1090
Seegal, D., *431
Seelig, M. G., 1224
Seelig, S., 1740
Seeliger, S., 1902
Seely, M. S., 923
Seemann, M., 429
Sefcik, J.A., 1310
Segall, H. N., 822
Seguini, A., 828
Seham, M., 331
Seibert, F. B., 332
Seidl, C., 1998
Seitz, A., 428
Selinger, A., 252
Sellards, A. W., 332, 1079
Selleras Pagés, J., 69
Sellers, T. E., 1227
Sellheim, H., 841, 1406, 2092
Selman, J. J., 159
Selter, H., 1902
Semaschko, N., 829
Semb, C., 430
Semb, O., 1090
Semon, H. C., 1819
Sen, R. T., 162
Sencert, L., 67
Sénèque, J., 1304
Sergent, E., 662, 752, 826
Serio, F., 1486
Serra, G., 1738
Serra Rabert, F., 1295
Sessions, M. A., 497
Sèvier, J. A., 1392
Sevringhaus, E. L., 59
Seyderhelm, R., 1740
Sézary, 163
Shapiro, I. J.,333
Shapiro, S., 418
Sharp, W., 1148
Sharpe, N., 1727
Sharpe, W., 922, 1001
Shattuck, H. F., *200
Shaw, B. H., 1399
Shaw, E. F., 999, 1732
Shaw, H. B., 1479
Shaw, R. C., 1480, 2085
Shaw, W. A., 998
Shaw, W. F., 1652
Shea, D. E., *274
Sheldon, J. H., 750
Shepard, W. P., 1076
Shephard, J. H., 911
Sheppe, W. M., 745, *1118
Sherman, L., *542
Sherren, J., 1229
Shillinger, J. C., 918
Shinkle, C. E., *1780
Shionoya, T., 1922
Shipley, P. G., 1225
Shipley, V. T., 819
Short, A. R., 1994
Shortt, H. E., 162, 1652
Shuman, J. W., 738, 1382
Sia, R. H. P., 1082, 1147
Sicard, J. A., 164
Sichan, V., 831
Sichel, A. W. S., 241
Sick, K., 343, 930
Sickenga, F. N., 2150
Sieburg, 1901
Siemens, H. W., 756, 1088, 1824
Siengalewicz, 1152
Sienkewicz, T. M., 577
Sievers, 1827
Sigmund, A., 1576
Signorelli, A., 1231
Silberstein, F., 666
Silberstein, S., 2148
Silfverskiöld, N., 589
Sillitti, G., 249
Silvan, C., 663
Silverston, J. D., 1302
Simard, 1401
Simchen, H., 342
Simkow, A., 667
Simmel, H., 755
Simmel-Rapp, E., 753
Simmons, C. C., 577
Simmons, E. W., *1265
Simmons, J. S., 333, 2033
Simon, C., *675
Simon, H., 1826
Simon, L., 70
Simon, R., 67
Simoncelli, G., 1085
Simpson, G. E., 1225
Simpson, R., 1151
Sindoni, B., 1232
Sinek, F., 168
Singer, G., 1089, 1903
Sinton, J. A., 1652
Sippel, A., 507
Sippel, P., 667
Siredey, 1898
Sison, A. G., 580
Sistrunk, W. E., 1393
Sivori, L., 165
Skinner, E. F., 583
Skinner, H. H., *1190
Slivinski, R., 1432
Sloan, LeR. H., *2021
Slomann, H. C., 920
Smead, L. F., 1728
Smiley, D. F., *540
Smit, C. E., 241
Smith, A. H., 578
Smith, A. L., 579
Smith, B., 1990
Smith, B. C., 999
Smith, C. K., 1478
Smith, C. S., 336
Smith, D. C., 1813
Smith, D. T., 1395
Smith, E. A., 244
Smith, E. C., 422
Smith, F. C., 819
Smith, F. L., *206
Smith, F. M., 239
Smith, G. M., 1145
Smith, H., *110
Smith, K. S., 661
Smith, L. H., 159, 1227
Smith, L. W., 1149, 2030
Smith, R. G., 1889
Smith, W., 1301
Smith, W. R., 576, *963
Smotrow, W., 1824
Smyth, F. S., 1891
Smythe, F. D., 1390
Smythe, F. W., 1470
Snapper, J., 665
Snell, M. W. *699
Snodgrass, W. R., 824
Snyder, F. F., 2082
Snyder, W. S., 1296
Soecknick, A., 1234
Sohn, B. J., 147
Sokoloff, B., 926
Sokolow, A. S., 1155
Soler, P. L., 504, 753
Solleri, S., 341
Sollgruber, 1008
Sollmann, T., *199, 921, 1729
Solomon, C. H., 1293
Solomon, H. C., *1512
Solomon, I., 163
Sommer, R., 829
Sonne, C., 508
Sonnenschein, C., 828
Sonnenschein, R., 411
Soparkar, M. B. 162, 1651
Sørensen, S. T., 508
Sorrel, E., 1004
Souboyran, 1997
Soupault, 662
Southam, A. H., 63, 1479
Southby, R., 2147
Southwood, J. R., 247
Souttar, H. S., 1228, 1995
Soutter, R., *171, *1179, *1261
Spalding, A. B., 60
Spangler, D., 1391
Spannuth, J. R., 997
Spatz, H., 73
Spector, H. I., 1145
Speed, K., 237
Speik, F. A., *2097
Spencer, G. F., 921
Spencer, H., 1226
Spencer, R. D., *791
Spengler, G., 931
Speroni, D., 250
Spiller, W. G., *106
Spiro, K., 168
Spiro, P., 71
Spitzer, W. M., 1731
Spohn, H., 159
Spremolla, G., 1656
Sprent, J., 1003
Spurr, R., 1403
Srb, O., 1010
Ssokoloff, S. E., 70
Stadie, W. C., 1988
Stachelin, R., 1089
Staemmler, M., 1740
Stafford, D. D., 825
Stahl, O., 1404
Stahl, R., 73, 344
Stander, H. J., 1147, 2083
Stanojevic, L., 429
Staohl, O.,
von Stapelmohr, S., 667, 1575
Stärcke, A., 1744
Stark, L., 579
Starr, P., 655, 1989
Starry, A. C., 1144
Staub, H., 505
Stearns, T., 337
Stechter, 1008
Steel, J., *857
Steele, A. E., 2083
Steele, H. M., *1262
Steenbock, H., 243, 578
Steenstrup, R., 1488
Stegemann, H., 342
Stein, G., 253
Stein, I. F., 1298
Stein, J. C., 1890
Stein, R. O., 589
Steinberg, B., 819
Steindl, H., 2148
Steinfeld, F., 428
Steinfield, E., *83, 1894
Stenhouse, H. M., *1926
Stenström, N., 1406
Stephani, J., 1153, 1232
Stephani, T., 1153, 1232
Stephansky, W. K., 1484
Stephenson, W., 2082
Stern, 664, 1233
Stern, A., 2149
Stern, G., 422
Stern, L., 663
Stern, R., 1575
Stern, W. G., 1817
Sternberg, W., 758
Steuber, 343
Stévenin, 828, 1481
Stevenson, D. W., 159
Stewart, C. A., 575
Stewart, H. E., 1721
Stewart, J. P., 1479
Stewart, M. J., 161, 582
Stewart, R. M., 582
Stieglitz, E. J., 655, 1729
Stiles, C. W., 990
Stiner, O., 1900
Stirling, W. C., *25
Stobie, W., 2087
Stockard, C. R., 1727
Stocker, C. J., 1572
Stockler, L., 753
Stoddard, I. L., 1816
Stoklasa, J., 2150
Stone, H. B., 234
Stone, J. B., 1993
Stone, J. S., 2080
Stookey, B., 918
Stooss, M., 1405
Stopford, J. S. B., 1228
Stoppato, U., 827
Storer, E. J., 422
Storrs, R. W., 242
Stout, J. *1770
Strachan, G. I., 246
Stracker, O., 1659
Strandberg, O., 338, 1236
Strandgaard, H., 2000
Stransky, E., 666, 1307
Strasberger, J., 343
Stratigopoulos, P., 585
Stratz, C. H., 2094
Straub, H., 587
Straus, H. H., 1226
Straus, D. C., *706, *1248
Strauss, A. A., *626, *1765
Strauss, H., 251, 505
Streng, J. C., 2150
Strothwood, J. H., 499
Stroganoff, 1743
Strohl, A., 340
Strouse, S., *546, 1989, *2111
Strube, 588
Struthers, E. B., 1896
Struthers, J. E., 2146
Stuart, F. W., 1817
Stuart, H. C., 1224
Stubbs, S., 1301
Stubbs, L. F. 1650
Stucky, J. A., 1388
Stuhl, K., 345
Stukowski, A., 427, 1487
Stulik, G. K., 239
Stümpke, 666
Sturgis, C. C., 919
Sturm, E., 62
Sturtevant, M., *964
Stutzin, J. J., 757
Sudeck, P., 1087
Suermondt, W. F., 1158
Sullivan, R. P., 235
Sullivan, W. E., 1816
Sully Périssé, 1085
Sümegi, S., 830
Sure, B., 920

Surmont, H., 248
Sussig, L., 1088, 2148
Sussman, A. A., *1664
Suter, F., 249
Sutton, H. B., 1644
Sutton, T. C., 60
Sutton, L. A., 819
Suzuki, T., 501, 1810
Swaminath, C. S., 1652
Swanberg, H., 240, *1932
Swanson, E. E., 1256
Swartz, J. H., 1890
Swarup, A., 2086
Sweany, H. C., 576, 820
Sweet, W. C., 655
Swezy, O., 918
Swift, G. W., 1299
Swift, H. F., 61, 998, 1640, 1647, 1988
Swoboda, H., 1309
Swyer, R., 65
Sydenstricker, V. P., 1398, 1811
Syllaba, L., 589
Symes, J. O., 337
Symes-Thompson, H. E., 1735
Symmers, D., 1473
Symonds, C. P., 1896
Syring, R., 1487
Szemző, G., 664, 1307
Szilárd, P., 1743
v. Szily, A., 588
Szirmai, F., 1404

T

Tadenuma, K., 345, 1232, 1997
Taft, A. R., 240
Tainter, M. L., 336
Takata, M., 757
Takenomata, N., 588
Talbot, F., 1008
Tallerman, K. H., 66
Tams, 1825
Tansard, A., 1737
Taoka, K., 253, 1814
Tapia, M., 342
Tardieu, A., 1654
Targowla, R., 927, 1737
Tarneaud, J., 752
Taussig, L. R., 240
Tavares, A., 1823
Taylor, G., 239
Taylor, H. L., 63, 2030
Taylor J., 1733
Taylor, J. H., 420
Taylor, J. V., *1107
Taylor, M. L., 1645
Taylor, R., 575
Taylor, R. H., 1381
Teachenor, F. R., 241
Teagarden, E. J., Jr., 62
Teague, O., 747, 748
Tedeschi, V., 753
Teige, K., 2094
Teissier, J., 926
Telcky, 931, 1233
Telfer, S. V., 2086
Telleria, 252
Tellgmann, 427
Tenckhoff, B., 1087, 1740
Tennant, C. E., *630, *1122
Tenney, B., 1729
Teposu, E., 1822
Terao, A., 1734
Ter Poorten, 1828
Terrien, F., 927
Terris, 1653
Thalhimer, W., *696, 1224, *1609
Thalwitzer, F., 1904
Thannhauser, S. C., 1086
Thannhauser, S. J., 1156
Thayer, W. S., 1721
Thaysen, T. E. H., 430, 758, 832
Thenon, J., 1307
Theodor, P., 2000
Theobari, A., 248
Thévenot, L., 1230
Thiel, R., 343
Thielié, T., 584
Thiroloix, J., 163
Thjötta, T., 1893
Thomas, A., 1737
Thomas, B. A., *281
Thomas, E., 1305
Thomas, G. J., 1477
Thomas, H. B., *2095
Thompson, C., 1811
Thompson, E. J., *288
Thompson, J. E., 1300
Thompson, S. E., 923
Thomsen, E., 932
Thomson, A. P., 1399
Thomson, J., 750
Thomson, J. O., 751
Thomson, M. S., 421
Thomson, S. C., 1902
Thomson, W. L., *542
Thornburgh, H. T., 419
Thorndike, A., Jr., *1120
Thorning, W. B., 1650
Thornton, L., 1811
Thrasher, R. L., 750
v. Thurzó, E., 666
Tidy, H. L., 825
Tiegs, O. W., 1733
Tietze, A., 1657
Tillett, W. S., 335, 2082
Tillmann, G., 1903
Timbal, L., 1005
Tinker, M. B., 1644
Tinnemeyer, W., 1659
Tiprez, J., 248
Tiscornia, A., 1306
Tisdall, F. F., 575, 1473
Titus, P., 1728
Todd, A. T., 421
Todd, L. C., 1145
Toenniessen, E., 930
Tolan, T. L., 750
Tománek, F., 1660
Tomasek, V., 2090
Tomb, J. W., 65, 1895
Tomcsik, J., 665
Tonnet, 1153
Toomey, J. A., 917
Torraca, L., 1482
Torrazza, J., 1900
Torres, F. R., 1574
Tournade, A., 1401, 1821
Tourneix, J., 1899
Tourreilles, 1403
Toverud, S., 578
Towle, H. P., 1890
Traina, S., 341
Tramer, M., 1482
Trask, J. D., Jr., *712, 1988
Traylor, G. A., 1810
Tréfouel, 1302
Trendelenburg, P., 1902
Trenti, E., 1656
Trifu, 1822
Trigueros, G., 587
Trimble, C. G., 1479
Troell, A., 932
Troise, E., 1154
Troisier, J., 661
Trost, K., 1907
Trotter, W., 2147
Truesdale, P. E., 2000
Tscherepnina, O. P., 1155
Tschmarke, G., 1657
Tso, E., 1479
Tucker, B. R., 1297
Tulgan, J., 1391
Tuma, J., 1010
Tuma, V., 1010
Tunnicliff, R., 1148
Turenne, A., 68, 250
Turley, L. A., *857
Turnbull, J. A., *1757
Turner, A. L., 1572
Turner, J. S., 1080
Turner, W. G., 576
Turpin, R., 593, 1153, 2088
Tuttle, W. W., 1889, 1893
Tweddel, F., 1079
Twyman, E. D., 238
Tzaico, A., 1899
Tzulukidze, A., 667

U

Uetani, E., 1816
Uiecia de la Plaza, R., 1483
Uiesko-Stroganowa, K., 1085
Ullmann, H., 252, 1825, 2149
Ulrich, 508
Ulrich, A., 663
Umber, F., 1485
Underhill, F. P., *9 243, 1991
Unterberger, F., 344
Upton, C. L., 1570
Urbain, 826, 926
Urbantschitsch, E., 1089
Urech, E., 827
Uribe Cualla, G., 250
Uroda, 1487
Uyeno, C., 422

V

Vacarezza, J. F., 505
Vaccarezza, R. F., 1484
Vacchelli, S., 504
Vagliano, M., 1303
Vaglianos, S., 339
Vahlen, E., 70, 831
Valerio, E., 1573
Vallack, A. S., 1829
del Valle, D., Jr., 250
del Valle, L., 1231
Vallée, 1302
Vallery-Radot, Pasteur, 425, 1481
Valtis, J., 826
Valverde, B., 2090
Vampré, E., 2089
van Balen, A., 758
van Beneden, J., 926
Van Rogaert, L., 1481, 1573, 2148
Van Bose, E., 580
Vance, R. G., 2078
van Creveld, S., 170
van Dam, E., 170
van Dam, J., 507
Van der Hoeden, J., 831
van der Hoff, H. L. M., 1010, 1736
Vanderhoof, D., 417
van der Speck, H., 254
van de Velde, J., 1898
van Dieren, 254
Van Dolsen, W. W., *103
Van Dyke, G. H., 1139
Van Gaasbeek, C. B., 750
van Herwerden, M. A., 1744
van Leersum, E. C., 253, 254
van Raamsdonk, C. P. W., 831
van Riemsdijk, M., 1576
van Rijnberk, G., 1660
Van Slyke, D. D., 1803
Van Wagenen, W. P., 990
Vanýsek, F., 758, 831, 2094
Varley, G. H., 1150
Vasquez-Colet, A., 1149
De Vauclerov, 1230
Vaudremer, A., 662, 1898
Vaughan, G. T., 499
Vaughn, A. M., 2081
Veddel, E. B., *764
Veitch, J., 659
Verasingam, K. V., 1151
Verbrycke, J. R., Jr., *1577
Vercelli, S., 1483
Vergoz, C., 2088
Vervloet, C. G., 1010
Vesley, B., 346
Viala, , 1736
Vickers, J. L., 1396
Victors, E. A., 334
Viesca y Lobatón, C., 1483
Vignes, H., 752, 1304, 1402
Villaret, M., 1004
Vincent, C., 1005
Vincent, S., 2147
Vinchon, J., 1152, 1231
Vinson, P., *859, 1227
Vivlet, H., 928, 1403
Vivaldo, J. C., 664
Vogel, K., 506
Vogel, R., 2092
Vogel, W., 1009, 1035
Vogl, A., 1658
Vogt, A., 165, 2038
Vogt, M. E., 657, 2079
Vos, V., 1479
Vohtz, L., 1483
Volicer, L., 1744
Volkmann, K., 1156
Vollhardt, W., 831
Vollmer, H., 168, 1487
von Meysenbug, L., 2078
Voorhoeve, H. C., 1488
Voron, 1402
Vorschütz, J., 829, 1087, 1740
Voss, H. E. V., 1903
Vossbeck, J., 757
Vulovic, L., 428
Vysin, V., 1310

W

de Waard, T., 254
Wachs, C., 1144
Wacker, 1080
Waddell, J. A., 1813
Wade, H. W., 159
de Waele, H., 1898
Wagener, H. P., 1808
Wagner, A., 1740
Wagner, E., 498
Wagner, F., 1903
Wahl, H. R., *1924
Wakamori, N., 1734
Wakeley, C. P. G., 825, 923
Walcher, K., 931
Waldbott, G., 1086
Waldenström, H., 1310
Waldorp, C. P., 69, 1078
Walker, A. L., 1652
Walker, A. M., *628
Walker, E. R. C., 1735
Walker, J., 1002
Walker, K. M., 583, 925, 1082
Walker, P. S., 1003
Walker, W. G., 1144, 1296, 1815
Walkey, A. E., 577
Walko, K., 72
Wallace, H. K., 657
Wallace, S. W., 1225
Waller, H. W. L., 65
Wallgren, A., 254, 590, 756
Wallgren, I., 1310
Wallhauser, H. J. F., 821
Wallin, I. E., 819, 1570
Wallner, A., 1659
Walser, J., 1401
Walter, H., 1821, 1898
Walterhöfer, 1744
Walters, W., *87, *624, 821
Walton, A. J., 422
Wang, C. C., 1989, *2111
Wanstrom, R. C., 1978
Ward, C. D., 1810
Wardill, W. E. M., 825
Warfield, L. M., 156, 1642, 1809
Waring, H. J., 923
Waring, J. B. H., 411
Warnshuis, F. C., 1959
Warren, S., 2082
Warren, S. L., 335
Wartenberg, R., 2149
Warthin, A. S., 821, 1803
Warwick, J., 825
Warwick, M., *1119
Wassermann, H., 1296
Wassermann, M., 2094
Wassink, W. F., 831
Wastl, H., 830
Waterman, N., 346
Watkins, R. M., 1474
Watkins, T. H., *1442
Watson, D., 925
Watson, L. F., *1935
Watson-Williams, E., 161
Watt, J., 1301
Watters, W. H., 1077
Watzold, P., 587
Waucomont, 1653
Waud, R. A., *1263
Waugh, J. F., *1584
Waugh, O. S., 499
Waugh, T. R., 576, 1146
Wauhope, G. M., 1895
Wearn, J. T., 2077
Weathers, T., 829
Weaver, G. H., *204
Webb, C. W., 1729
Webb, G. B., *944, 1392, 1461
Webb, R. A., 824
Webb-Johnson, A. E., 1150, 1819
Weber, E., 345
Weber, F. P., 66, 1143
Webster, A., 1735
Webster, R., 1302
Weckerling, 2150
Weckowski, C., 926
Weech, A. A., 575, *1245
Weeden, W. M., *1165
Weekers, L., 585
Wehefritz, E., 1738
Weichardt, 428
Weichbrodt, R., 167
Weidman, F. D., 1145
Weidner, E., 1999
Weigel, B. J., *457
Weil, 1827
Weil, M. P., 248, 826, 1653, 1997
Weiler, E. S., 929
Weinberg, M., 665
Weiner, E., 931
Weinstock, M., 575, *952
Weintraub, A., 1009
Weiser, 1234
Weiss, D. W., 1148
Weiss, H., 1647
Weiss, H. B., 1077
Weiss, J., 1743
Weiss, M., *12
Weiss, R., 665
Weiss, R. F., 1824
Weiss, St., 1155
Weiss, Soma, 1815
Weissenbach, R. J., 2038
Weissmann-Netter, 248, 926
Weisz, E., 1743
Weitgasser, H., 755
Weitz, W., 664, 1741
Weitzel, L., 67
Welch, A. S., 1217
Welfeld, J., *110
Welker, W. H., 1893
Wells, H. G., 576, 1984
Wells, H. S., *1599
Weltmann, 170
Welton, T. S., 1143
Wenckebach, K. F., 2147
Went, S., 2091
Werner, P., 1486
Werner, R., 587
Wernstedt, W., 1575
Wertheimer, J., 1824
Wertheimer, P., 249, 928, 1655
Wertheimer, R., 2093
v. Werthern, A. M., 1741
West, H. F., 1990
West, L. B., 1471
Westenhöfer, M., 2093
Westphalen, H., 1907
von der Weth, G., 1030
Wetmore, A. S., 1991
Weygandt, W., 252
Weyl, L., 165, 584
Wharry, H. M., 1651, 1897
Wheatley, M. A., 1988
Wheeler, J. B., 919
Wheeler, W. I., de C., 162
Whipple, A. O., 999
Whipple, G. H., 335, 910, 1821, 1892
White, B., 497, *1675
White, J. E., 409
White, P. A., *695
White, P. D., 497, 1476, 1722
Whitehouse, H. H., 1630
Whitman, A., 1818, *1914
Whitney, H. B., *33
Whittemore, W., 1478
Wholey, C. C., 910
Widal, F., 1402
Widowitz, P., 1158
Wiechmann, E., 756, 1575
Wiedemer, L., 420
Wiedhopf, O., 427, 1902
Wieland, H., 1155, 1405
Wiener, S., 499
Wiesel, F., 1660
Wigham, E. F., *1114
Wilbrand, 168
Wilbur, R. L., 1968
Wild, E., 1741
Wildbolz, H., 586
Wildegans, H., 344
Wilder, J. M., 579, 2084
Wile, U. J., 822
Wilens, G., 243
Wilhelm, T., 67, 1655
Wilkie, P. D., 1994
Wilkins, L., *1599
Willemse, A., 429
Willerding, H. J., 1086
Williams, C., 1893
Williams, F. W., 247, 824
Williams, J. L., 1728
Williams, J. R., 1027
Williamson, A. C., *1107, 1144
Williamson, C. S., 1837
Willier, B. H., 1569
Willis, H. S., 1809
Willis, T. A., 1817
Willius, F. A., 1397, 1645, 1649
Willson, E. F., 583
Wills, L., 825
Wilson, C. R., 1147
Wilmaers, A., 1729
Wilson, C., 422
Wilson, D. W., 157
Wilson, F. N., 1722, *1754, 1896
Wilson, G., 60, 333, *1407, *1667, 1814
Wilson, J. R., 239
Wilson, M. G., 575, *759
Wilson, R. S., 1225
Wiltschke, F., 342
Wimmer, A., 1576
Winckel, C. W. F., 668
Winkelman, N. W., *1407, 1814
Winkler, K., 1657
Winter, G., 827, 1405
Winter, L. B., 1301
von Winterfeld, H. K., 664, 1156
Winternitz, F., 1743
Winterstein, O., 1232
Wirz, F., 1743
Wise, B. T., 1810
Wise, W. D., *1936
Wiskott, A., 344
Wislocki, G. B., 819
Witt, W. H., 1472
Wittgenstein, A., 1233, 1574
Wittgenstein, H., 253
Wittmann, J., 578
Wöhlisch, E., 72, 1575, 2092
Wolbach, S. B., 748, 1888
Woldenberg, S. C., *1027
Wolf, , 340, 1653, 1654
Wolferth, C., 1474
von Wolff, K., 1392
Wolff, L. K., 502
Wollheim, E., 1901, 1902
Wollman, E., 926, 1302
Wolterman, H. W., 1075
Wolvius, R. J., 668
Woo, S. T., 1147
Wood, C. B., 1631
Woodcock, H. De C., 247
Woods, A. C., *2105
Woods, J. O., 745
Woods, R., 924
Woody, W. S., 1149
Woodyatt, R. T., 1398
Woolley, J. S., 1392
Woolsey, B. F., 1984
Worcester, J. N., 1469
Woringer, P., 340
Worms, G., 927
Wortman, J. L. C., 1744
Wright, A. E., 925
Wright, F., *717
Wright, G. J., 2145
Wright, L. H., 497
Wu, H., 751
Wulff, F., 827, 1828
Wundt, N., 1999

Würtzen, C. H., 1904
Wusthoff, R., 343
Wutki, O., 73
Wycoff, J., 2081
Wyder, T., 1403, 1997, 2000
Wyeth, G. A., 821, 1643

V

Yaccel, J., 1303
Yakolievitch, V., 424
Yamagiwa, I. K., 2082
Yampolsky, J., 1298
Yanagi, K., *1169
Yanagihara, R., 501
Yasaki, Y., 168
Yergason, R. M., 1478
Yippö, A., 1158
Yoshida, S., 1994
Youmans, J. B., 1570, 1809, *1833
Young, A. G., 1477
Young, C. C., 1298
Young, H. H., 236, 656, 658, *669, 747, 999, 1732
Young, J. S., 2147
Young, R. A., 1151, 1399
Young, W. A., 337

Z

Zaaijer, J. H 1235
Zadek, I., 251, 921
Zahorsky, J., 420, 1000
Zahradnický, 2094
von Zalka, E., 2090
Zander, P., 73
Zappert, J., 1485
Zdansky, E., 503, 1008
Zeckwer, I. T., 1731
Zeeman, 663
Zee-Whay, C., 1234
Zehnter, E. N., 340, 1004
Zeller, A. H., 227
Zeisler, E. P., *466
Zeltner, N., 1743
Zeno, A., 929
Zerner, H., 1088, 1309
v. Zezschwitz, P., 2093
Ziegler, M., 575
Zierold, A. A., 1393
Zilva, S. S., 500
Zimmer, H., 587
Zimmermann, R., 70
Zingher, A., 748, *1180, 1217, 1640
Zipf, 428
Zizy, R., 925
Zollikofer, R., 1403
Zollinger, F., 1738
Zolog, M., 926
Zondek, B., 830
Zondek, H., 1090, 1485
Zondek, S. G., 1901
Zong-Yong, T., 1653
Zuccarelli, J., 1482
Zuelzer, G., 252
Zunz, E., 926, 1230
Zwaardemaker, H., 926
Zweifel, P., 346
Zweig, W., 1825

INDEX TO PAGES

OF THE JOURNAL, ACCORDING TO WEEKLY ISSUES—VOLUME 82, JANUARY-JUNE, 1924

Pages	No.	Date
1- 74	1	Jan. 5
75- 170	2	Jan. 12
171- 254	3	Jan. 19
255- 346	4	Jan. 26
347- 430	5	Feb. 2
431- 508	6	Feb. 9
509- 590	7	Feb. 16
591- 668	8	Feb. 23
669- 758	9	Mar. 1
759- 832	10	Mar. 8
833- 932	11	Mar. 15
933-1010	12	Mar. 22
1011-1090	13	Mar. 29
1091-1158	14	Apr. 5
1159-1236	15	Apr. 12
1237-1310	16	Apr. 19
1311-1406	17	Apr. 26
1407-1488	18	May 3
1489-1576	19	May 10
1577-1660	20	May 17
1661-1744	21	May 24
1745-1828	22	May 31
1829-1904	23	June 7
1905-2000	24	June 14
2001-2094	25	June 21
2095-2204	26	June 28

4192 '18